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V 000	INITIAL COMMENTS A complaint survey was completed on October 15, 2019. The complaint was unsubstantiated. (Intake #NC00156407). 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	DHSR-Mental Health NOV 12 2019 Lic. & Cert. Section	
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider	V 367	Incident Report training was conducted for QP. The "Incident Response and Reporting Manual Feb. 2011" was used as a guide. On 10/30/19, a hands-on training was done with QP in which	10/30/19 & on-going

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

[signature] MS, CRC, LPC — Clinical Consultant — 11/5/19

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V 367	Continued From page 1 shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident;	V 367	an incident was reported in NC IRIS System. Clinical Consultant reviewed the ~~Categories of~~ "APPENDIX B: Criteria for Determining Level of Response to Incidents" and "APPENDIX C: Incident Response Overview" with emphasis on Reporting timeframes. All the above have increased the competence	10/30/19 ongoing

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V 367	Continued From page 2 (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report a Level III incident to the Local Management Entity (LME) within 72 hours of becoming aware of the incident. The findings are: Review on 10/7/19 of the facility's incident reports revealed: -No documentation of a level III incident report on 9/7/19 which involved client #1 being sexually assaulted by an unidentified male in a local library Interview on 10/9/19 with the Qualified Professional (QP) revealed: -Was made aware of the incident on 9/7/19 at the local library involving client #1 and an unidentified male. -The former QP was responsible for submitting reports into the Incident Reporting Improvement System. -"I will be responsible for completing the incident reports into IRIS from now on. I want to be incompliance ..."	V 367	of the QP.	10/30/19

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V 367	Continued From page 3 interview on 10/15/19 with the Licensee revealed: -Had been trained on how to submit level III incident reports -The QP was responsible for submitting the incident reports -Had told the legal guardian and the QP about the incident involving client #1 being sexually assaulted on 9/7/19 -Was not sure why an incident report was not submitted into the Incident Reporting Improvement System within the mandated time frame.	V 367		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.	V 512	Staff members were trained in how to properly supervise clients in their care. The training included how to reduce contact with strangers, how to monitor clients physical environment while keeping eyes on who is around the client. It also	11/5/19

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V 512	Continued From page 4 This Rule is not met as evidenced by: Based on record reviews and interviews, 2 of 4 staff (#1 and the Licensee) neglected and failed to protect 1 of 2 clients (#1) from harm. The findings are: Review on 10/7/19 of client #1's record revealed: -An admission date of 8/10/10 -Diagnoses of Mild Intellectual Disability, Intermittent Explosive Disorder, Post-Traumatic Stress Disorder, Unspecified Depressive Disorder, Unspecified Psychotic Disorder, Personality Disorder Not Otherwise Specified, Obesity and Hypertension -An assessment dated 8/10/10 noting "in need of residential placement, was living temporarily in an Alternative to Family Living facility (emergency placement), has a history of abuse and exploitation by her family and a history of psychiatric inpatient admissions, had fetal alcohol syndrome at birth, has seasonal allergies, history of thoughts and threats of suicide, mood discovery, behavioral issues and psychosis, needs motivation, needs supervising, monitoring, redirection and positive reinforcement, needs assistance with her personal hygiene, money management skills, requires support with safety awareness skills and required 24/7 monitoring of health and safety, requires extra time to communicate essential needs, will refuse rules and directions and can be disruptive, has difficulties controlling her anger, can be aggressive, elope and cause property destruction, requires close supervision as she has a history of elopement and requires monitoring at all times, lacks safety awareness skills and requires monitoring at all times, was sexually abused in the past, ."	V 512	included protecting and removing the client from unsafe environments. Clinical Consultant who ~~consult~~ conducted the training reiterated to staff NEVER to leave clients alone; clients must always be in their sight. It is important to mention that the training was not limited to Client #1 in the report, but to all residents.	11/5/19

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V 512	Continued From page 5 -A treatment plan dated 10/1/19 noting "will receive residential supports to acquire, improve and retain skills in self-help, general household management and meal preparation, personal finance management, socialization and other adaptive areas, will increase her independent living skills by completing her household chores and tasks, will increase her independent living skills by completing her laundry, will maintain a neat appearance by thoroughly completing her personal hygiene tasks, will participate in meal preparation, will increase her money management skills by creating a budget, will increase her self-esteem and self-image by selecting and wearing appropriate clothes, will identify the correct value and amount of currencies, will increase her safety skills in the community, looking both directions when crossing the street, will decrease risky behaviors by not giving out her private and confidential information to unauthorized persons and by not socializing with unfamiliar individuals, will increase her anger management skills by using coping skills such as personal time-outs, counting to ten, deep breathing, listening to music and walking, will decrease unacceptable behaviors by not walking away without permission, not eloping and becoming angry when she is told no, and to promote good health, will exercise by walking for at least 30 minutes 3 days per week." -No documentation that client #1 was capable of unsupervised/independent time in the home or community. -An individual behavior support plan/crisis plan, dated 7/1/19, noting "continues to require close supervision in the community and day program to prevent unsafe behaviors such as elopement, approaching strangers whom she perceives as friends and sharing personal information inappropriately, needs prompts not to invade	V 512	See pg 4 pos	

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V 512	Continued From page 6 others' personal space and to avoid excessive physical contact with others. To prevent elopement from occurring, staff needs to monitor her at all times and be at arm's length at all times. Certain triggers that can cause elopement are [client #1] not getting attention, not getting her way or when she is upset about something. If [client #1] walks off, follow her for safety. Walk with her to a designated area and prompt her to remain at arm's length may help define boundaries of personal space." Review on 10/8/19 of staff #1's record revealed: -A hire date of 6/20/13 -A job description of Paraprofessional -Staff #1 was trained on client #1's treatment and individual behavior support plans. Review on 10/8/19 of the Licensee's record revealed: -A hire date of 6/6/07 -A job description of Paraprofessional -The Licensee was trained on client #1's treatment and individual behavior support plans. Review on 10/7/19 of the 911 print out from a local police department, for 9/7/19, revealed: -At 4:50pm, a 911 call was received -The security officer at the library placed the 911 call -"A female just came inside the library stating she had been raped. It happened not long ago. No further information available." Review on 10/7/19 of the local police department's incident/investigation report, dated 9/7/19, revealed: -At 4:50pm on 9/7/19, the Detective responded to a call of a sexual assault. Met with the victim (client #1) who advised she had been assaulted.	V 512	See page 405	

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V 512	Continued From page 7 Review on 10/7/19 of the Reporting Officer's Narrative dated 9/7/19, revealed: -"Upon arrival on scene, [staff #1] and [client #1] were sitting in a back-conference room (of the library) waiting for officers. [Staff #1] introduced herself as the staff of the All About You Group Home. She advised [client #1] was a resident at the facility. They had arrived at the library as a field trip. I was advised [client #1] had intellectual disabilities and operates on the level of an elementary school aged child and was prone to exaggeration in her stories and was very emotionally immature. According to the story [client #1] related to [staff #1] and then related to me (the detective), she saw a guy in the library who she had seen out walking on the street before. When she got onto the elevator, the subject followed her in. The male pulled the emergency stop knob and stopped the elevator while just the two of them were inside it. She stated that the male subject raped her from the front and from behind. The subject then restarted the elevator and ran away when the doors opened." -There was no camera in the elevators. -The decision was made to have client #1 interviewed by a more qualified person with experience in interviewing victims with disabilities. -"[Client #1] needed to go to the hospital to collect a SANE (Sexual Assault Nurse Examiner) kit to help determine if there was an assault." Review on 10/7/19 of a local library's floor plan revealed: -There were three stories to the building -The first floor contained a snack area, children's books, a main lobby area with stairs in the middle of the building and elevators located on each side of the lobby	V 512	See page 4 of 5	

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V 512	Continued From page 8 -The second floor contained a magazine and newspaper area, a computer area and a non-fiction area which included videos and movies. -On each floor there was a reader's services area to check out items -A camera was in the middle area of each floor Review on 10/7/19 of the local library's video surveillance system revealed: -The video camera was not working on 9/7/19 -Only still shots were available -On the second floor of the library, the camera was in the main common area with a view of the hallways and reader's services, the stairwell and the two elevators -On 9/7/19, at 4:32:06pm, a still photo of the hallway -The hallway leads to the non-fiction and video/movie area -At 4:32:19pm, the still photo showed two people leaving the hallway headed to the common area -One person (the unidentified male) was ahead of the other person (client #1) -At 4:32:22pm, a closer still photo showed an unidentified male walking ahead of client #1 as she followed -At 4:32:24pm, the two people are in the common area. -At 4:32:28pm, in the far upper left corner of the still photo, the unidentified male and client #1 were in the elevator -There were no other persons present in the still photos. Interview on 10/7/19 with client #1 revealed: -Went to the library with facility staff every Saturday afternoon -Was allowed to be alone on the second floor of the library to check out books.	V 512	See page 4 of 5	

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V 512	Continued From page 9 -"It is my independent time. Staff stays on the first floor with [client #2] because she can't talk. [Staff #1] and [theLicensee] said I could be independent and go to the second floor. They always let me go up there alone." -On 9/7/19, staff #1, client #1 and client #2 went to the library. -Went to the second floor, alone, and was approached by an unidentified male -"Here he comes. I hadn't seen him before. I talked to him and then he touched me on my booty. Then he pulled out his weenie and told me to touch it. He pushed my hand down on his weenie. He picked up my books and my bookbags and we were going to the elevator." -The unidentified male did not push a button for a specific floor and the doors closed. -"He took my pants, panties and shoes off. Then he took off his pants and underwear." -Denied anyone else present on the elevator. -"He told me he was going to do something to me. He put his thing (penis) in my front (vagina) and my back (bottom)." -Once the doors to the elevator opened, the unidentified male ran out of the elevator. -"I was crying and went to the staff (librarian) and told her I was raped. Then the security guard and the police came. [Staff #1] was still downstairs and the security guard had to go and get her." -The police arrived at the library and spoke to client #1 and staff #1. -"I went to the hospital later and I did not like what they did (rape kit)." Interview on 10/4/19 with a local city's police detective revealed: -Client #1 was sexually assaulted in the elevator at a local library on 9/7/19 -Client #1 was on the 2nd floor of the library, alone, while staff #1 was on the 1st floor	V 512	See page 495	

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V 512	Continued From page 10 -The surveillance video on 9/7/19 was not working -There were still photographs from the video on 9/7/19 -Client #1 was in the elevator with an unidentified male -Client #1 was consistent with the details of what occurred on 9/7/19 -A forensic interview was conducted on 10/3/19. -Given client #1's child-like mentality, she was interviewed by a child forensic interviewer. -Client #1, based on information received, came to the library twice a week from approximately 3:30pm until closing at 6pm. -Staff #1, according to information gathered, stayed on the 1st floor and "allowed [client #1] to roam around unsupervised on the 2nd floor." -Client #1 did not understand the dangers of being around strangers. -"Apparently, she was vaginally and anally penetrated while on the elevator and according to interviews with the librarian, [client #1] comes into the library all the time unsupervised. -Client #1 was seen at the local emergency room on 9/7/19 where a rape kit was completed. -The results of the rape kit would not be available for several months Further interview on 10/10/19 with the local city's police detective revealed: -Had identified the perpetrator -He was a registered sex offender and he had been listed as a suspect in a forcible rape that occurred on 4/23/19. Interview on 10/7/19 with the librarian revealed: -Was working at the library on 9/7/19 -Referred to client #1 and staff #1 as "regular customers" -"They usually come in around 4pm until we close	V 512	See page 405	

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V 512	Continued From page 11 (at 6pm) on the weekends. I am very familiar with [client #1] as she always asks for assistance. She is always unsupervised on my floor (second)." -Described client #1 as very "child-like, vulnerable, trusting and innocent" -Remembered seeing client #1 go to the back bookshelves "where she normally goes" -Did not recall seeing her return until later in the afternoon. -"I was working at the check-out area on 9/7/19. I looked up and saw [client #1] shaking and crying while she was waiting in line to check out her books. I asked her what was wrong, and she told me she had been raped." -Immediately called the security guard to come to the second floor and the police were contacted -There were no facility staff on the second floor with client #1 when the incident occurred. -"Once her caretaker (staff #1) was located, I took everyone to the back of a conference room to wait for the police." -The police arrived and interviewed client #1, staff #1 and the librarian. Interview on 10/7/19 with the security guard revealed: -Had worked at the library for several years -Had observed client #1 wander around the library with no supervision -A sexual assault occurred on 9/7/19 which involved client #1 and an unidentified male -He was not working on that day and the security guard that was working on 9/7/19, had moved to a west coast state and there was no contact information for her available. -The video surveillance camera was not working on 9/7/19 as the server was down. -Had pulled still photos from the second floor of the library and gave them to the police. -Still had the still photos saved from 9/7/19.	V 512	See page 495	

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V 512	Continued From page 12 -Had reviewed the still photos -The photos showed the unidentified male walking ahead of client #1 as they left a hallway -The photos also showed only the two of them. -There was no facility staff on the second floor or the hallway -The unidentified male and client #1 got into the far-left elevator. -"[Client #1] was super friendly and would always come up to me and talk. She is very trusting and thinks everyone is her friend. She does not appear to have any 'stranger danger'. I don't think she is appropriately supervised and needs to be." Interview on 10/8/19 with staff #1 revealed: -Had been trained in client #1's treatment and individual behavior support plans -Was aware of client #1's tendencies to elope and the requirement of 24/7 supervision in the community due to her behaviors. -Worked as needed on Saturdays at the facility -Had worked at the facility on 9/7/19 -Took client #1 and client #2 to the library on 9/7/19 -"The clients go to the library every weekend, either when I am working or when [theLicensee] is working." -Stated client #1 did not have any unsupervised time in the facility or the community -"She tends to run off when she is told no or does not get her way. She has always been that way." -Client #1, for the past several years, had been allowed to be unsupervised on both the first and second floors of the library for "independent time" -"She likes to look at the books and movies. If you try to follow her, she will have a behavior where she hits, kicks and screams. It is easier to just let her be alone at the library." -On 9/7/19, client #1 headed to the second floor of the library	V 512	See page 495	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-880	A. BUILDING: _____ B. WING _____	10/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 512	Continued From page 13 -Staff #1 and client #2 remained on the first floor -Staff #1 sat on the bench near the left elevator waiting for client #1 to return to the main floor -"She was only up there for a few minutes to check out her books like she normally does. All the librarians know her." -Later, on 9/7/19, the security guard came to the first floor to tell staff #1 what had happened with client #1 and the unidentified male. -"Nothing like this has ever happened before." Interview on 10/9/19 with the Qualified Professional revealed: -Was made aware of the incident on 9/7/19 where client #1 was sexually assaulted at a library. -Client #1 was always to be supervised given her tendency to elope -"After the incident occurred (on 9/7/19), I had a long discussion with [theLicensee] to clarify that [client #1] does not have unsupervised time. I said [client #1] was always to be monitored while in the home and community. I was not aware [client #1] was given so much liberty to roam around the library. I was told she could check out books alone and to check them back in. I tried to get clarity with [theLicensee] as to why/how this took place. I tried to get a visual. I said she must be supervised at all times." -"I was told by [theLicensee], she and [staff #1], allowed [client #1] a 'little bit of freedom' at the library. I was also told there had not be any issues at the library and [client #1] always returned to staff with no incidents ...but this is an individual that had a history of elopement ..." -Stated unsupervised time was not warranted for client #1 and at no time should she be alone. Interview on 10/15/19 with theLicensee revealed: -Had been trained in client #1's treatment and individual behavior support plans	V 512	See page 405	

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V 512	Continued From page 14 -Was aware of client #1's tendencies to elope and the requirement of 24/7 supervision in the community due to her behaviors. -"She will talk to strangers and think they are her friends." -Client #1 was taken once a week to the local library -TheLicensee stated she had allowed client #1 to be unsupervised on the second floor of the library several times. -"This was to practice her independence." -Was unable to recall if she told staff #1 to allow client #1 to be unsupervised while in the library. -"It was more of me assuming [staff #1] would allow the unsupervised time on the 2nd floor. [Client #1] had been doing so well with being on the second floor alone ..." -Staff #1 took client #1 to the local library on 9/7/19 -Received a telephone call from staff #1 stating client #1 had been sexually assaulted on the elevator while alone on the second floor. -Was in a meeting when she received staff #1's telephone call -"I immediately headed to the library, spoke with the police and then we transported her to the hospital ..." -Client #1 had not be allowed to return to the local library since 9/7/19. Review on 10/15/19 of the facility's plan of protection dated 10/15/19 and written by both theLicensee and an outside agency's Clinical Consultant (CC) revealed: -"What will you immediately do to correct the above rule violation in order to protect clients from further risk or additional harm? All the clients will immediately be supervised 24/7 in the home and the community" -Describe your plans to make sure the above	V 512	See page 405	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 512	Continued From page 15 happens. The CC will supervise the QP to monitor on-going 24/7 supervision." Client #1 had diagnoses of Mild Intellectual Disability, Intermittent Explosive Disorder, Post-Traumatic Stress Disorder, Unspecified Depressive Disorder, Unspecified Psychotic Disorder, Personality Disorder Not Otherwise Specified, Obesity and Hypertension. She required support with safety awareness skills and 24/7 monitoring for her health and safety. Her behavior support plan identified that she required close supervision in the community to prevent unsafe behaviors such as elopement, approaching strangers whom she perceives as friends and sharing personal information inappropriately. She needs prompts not to invade others' personal space and to avoid excessive physical contact with others. Staff #1 and the Licensee had been trained in client #1's treatment and individual support plans and were aware she was to be monitored 24/7. Both staff #1 and the Licensee had taken client #1 to the library on multiple occasions and allowed client #1 to be unsupervised on the second floor. This decision was made without consultation with the treatment team or the Qualified Professional. On 9/7/19, staff #1 took client #1 to the library. Staff #1 remained on the first floor while client #1 went to the second floor. Video screen shots on 9/7/19 showed client #1 leaving a hallway as she followed an unidentified male to the elevator. At 4:32pm, client #1 got into the elevator with the unidentified male. Staff #1 remained on the first floor. During client #1's elevator trip from the second floor to the first floor, she was sexually assaulted by the unidentified male. Her story of being sexually assaulted was consistent when she told a librarian, a police officer, the forensic interviewer and this surveyor. This deficiency	V 512	See page 485	

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V 512	Continued From page 16 constitutes a Type A1 rule violation for serious neglect and failure to protect from harm and must be corrected within 23 days. An administrative penalty of $2,000.00 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 512		

MULTI-THERAPEUTIC SERVICES. INC

INSERVICE TRAINING

Trainer: Francis Ndinya, MS CRC LPC
(CLINICAL CONSULTANT)

Date: 11/5/2019

Outline of Training: 2hours

Training in Supervision of Consumers to Ensure their Safety

1. How to properly supervise consumers in the home and community.
2. Reducing chances of contact with the perpetrator or potential perpetrators
3. Escorting consumers to all places in the community -Never to be left alone
4. Helping Consumers to identify safe friends and safe places
5. Helping Consumers to understand basic information on sexual violence, personal boundaries, personal safety and community resources.
6. Teaching consumers how about safety circles and how to maintain safety circles.

I, the undersigned Staff do attest that I understand the content of this in-service training.

E

Staff Name	Staff Signature
Ethel Muncy	Ethel Muncy 11/5/19
TeNisha Fields	TeNisha Fields 11/5/2019
Danielle R. Settle	Danielle R. Settle 11/5/2019
Daisy Mack	Daisy Mack 11-5-19

Francis Ndinya MS, CRC LPC
Trainer's Signature

11/05/2019
Date

MULTI-THERAPEUTIC SERVICES, INC

INSERVICE TRAINING

Trainer: Francis Ndinya, MS CRC LPC
(CLINICAL CONSULTANT)

Date: 10/30/2019

Outline of Training:

Incident Response and Reporting for the Qualified Professionals on Staff.
Focus was on "When to File" (Table 1. Reporting Timelines) on page 5 of **Incident Response and Reporting Manual (February 2011 edition).** Other training materials are APPENDIX A: GLOSSARY on page 18, and APPENDIX B: CRITERIA FOR DETERMINING LEVEL OF RESPONSE TO INCIDENTS at pages 20-25 of the Manual.
A copy of the Manual was provided for the QPs to use as a reference Guide for future incidents and Reporting.
3. Completion of a live reporting of Incident in IRIS

I, the undersigned Qualified Professional do attest that I understand the content of this in-service training.

Staff Name	Staff Signature
Antwone B. Harper BSQP	Antwone B. Harper BSQP

Trainer's Signature — F Ndinya MS, CRC, LPC

Date — 10/30/2019