NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

December 11, 2019

Telicia Bass
RBC Health Care Solutions, Inc.
P.O. Box 1735
Fuquay Varina, NC 27526

Re: Annual and Follow up Survey completed December 9, 2019
RBC Health Care Solutions, Inc., 1335 Lassiter Road, Four Oaks, NC 27524
MHL # 051-216
E-mail Address: rbchealthcaresolutions@yahoo.com

Dear Ms. Bass:

Thank you for the cooperation and courtesy extended during the Annual and Follow up survey completed December 9, 2019.

As a result of the follow up survey, it was determined that none of the deficiencies are in compliance. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Re-cited standard level deficiencies.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is 1/8/2020.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is 2/7/2020.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Bryson Brown at 919-855-3822.

Sincerely,

Kimberly R Sauls
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc:

DHSR@Alliancebhc.org
qmemail@cardinalinnovations.org
DHSRreports@eastpointe.net
Pam Pridgen, Administrative Assistant

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL051-216	A. BUILDING: ______ B. WING ______	R 12/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RBC HEALTH CARE SOLUTIONS, INC	1335 LASSISTER ROAD FOUR OAKS, NC 27524

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 12/9/19. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness.	V 000	DHSR - Mental Health JAN 2 2020 Lic. & Cert. Section	
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and	V 108	RBC Healthcare Solutions will have all staff trained and recertified in CPR and First Aid. Home Manager will monitor files on a Annual basis to check for required training completion date 12-21-19	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE [signature] (X6) DATE 12-25-19

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V 108	Continued From page 1 clients. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure staff had training in Cardiopulmonary Resuscitation and First Aid for two of four audited staff (staff #1 and staff #2). The findings are: a. Review on 12/6/19 of the facility's personnel files revealed: -Staff #1 had a hire date of 12/15/15. -Staff #1 was hired as a Residential Care Specialist. -Staff #1's Cardiopulmonary Resuscitation and First Aid training expired on 9/2/19. -There was no documentation of current training in Cardiopulmonary Resuscitation and First Aid for staff #1. b. Review on 12/6/19 of the facility's personnel files revealed: -Staff #2 had a hire date of 12/21/15. -Staff #2 was hired as the Operations Manager. -Staff #2's Cardiopulmonary Resuscitation and First Aid training expired on 9/2/19. -There was no documentation of current training in Cardiopulmonary Resuscitation and First Aid for staff #2. Interview on 12/6/19 with the Support Staff revealed: -Staff #1 and staff #2 did work alone with clients. -He was the Cardiopulmonary Resuscitation and First Aid trainer for the agency. -He just recently realized staff #1 and staff #2's	V 108		

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V 108	Continued From page 2 Cardiopulmonary Resuscitation and First Aid training had expired. -He thought he still had time to get staff #1 and staff #2 trained. -He confirmed there was no documentation of current training in Cardiopulmonary Resuscitation and First Aid for staff #1 and staff #2.	V 108		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to conduct fire and disaster drills under conditions that simulate emergencies. The findings are: Review on 12/9/19 of the facility's fire drill log revealed the following: -7/2/19-2nd shift -9/16/19-2nd shift	V 114	RBC Healthcare will have an staff meeting with employees and discuss the importance of fire drills. RBC Home Manager will be responsible for completing fire drills and disaster drills as required. QP will review the fire and disaster drill log on a monthly basis	

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V 114	Continued From page 3 -There were no fire drills conducted during the 2nd quarter of 2019. Review on 12/9/19 of the facility's disaster drill log revealed the following: -There was no documentation staff conducted any disaster drills in 2019. Interview with client #1 on 12/9/19 revealed: -She was not sure if staff had conducted any fire and disaster drills with them. Interview with client #3 on 12/9/19 revealed: -Staff had conducted fire and disaster drills with them. -She was not sure how often the fire and disaster drills were conducted. Interview with the Support Staff on 12/9/19 revealed: -Group home staff normally worked two separate shifts. -Staff #2 was responsible for ensuring the fire and disaster drills were conducted. -He confirmed staff failed to conduct fire and disaster drills under conditions that simulate emergencies. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114	and talk with the residents to be sure drills are being conducted as required. Completion date 1-8-20	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe	V 118	RBC Healthcare Home manager will be reviewing the MAR on a monthly basis Manager will discuss	

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V 118	Continued From page 4 drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow the physician's order for one of three clients (#1), failed to keep the MAR current for one of three clients (#1) and failed to record administered medications immediately affecting two of three clients (#2 and #3). The findings are: 1. The following is evidence the facility failed to follow the physician's order.	V 118	with staff the importance of following the Medication orders. Manager will contact doctor to ask for a PRN order for medication and then get the order to the pharmacy. completion date 1/10/20	

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V 118	Continued From page 5	V 118		

Review on 12/9/19 of client #1's record revealed:
-Admission date of 3/8/18.
-Diagnoses of Schizoaffective Disorder, Huntington's Disease, Multiple Sclerosis, Hypothyroidism, Hyperlipidemia and Vitamin D Deficiency.
-Physician's order dated 7/1/19 for Polyethylene Glycol 3350, one capful in the morning.

Interview with staff #2 on 12/9/19 revealed:
-Client #1 was administered the Polyethylene Glycol 3350 most days.
-Some days client #1 did not take the Polyethylene Glycol 3350.
-The Polyethylene Glycol 3350 would sometimes make client #1's stools loose.
-Client #1 would sometimes take the Polyethylene Glycol 3350 as needed.
-He confirmed the facility staff failed to follow the physician's order for client #1.

Interview with the Support Staff on 12/9/19 confirmed:
-The facility staff failed to follow the physician's order for client #1.

2. The following is evidence the facility failed to keep the MAR current.

Review on 12/9/19 of client #1's record revealed:
-Physician's order dated 7/1/19 for Divalproex Sodium ER 500 mg, two tablets daily; Risperidone 4 mg, one tablet two times daily; Chlorpromazine 200 mg, one tablet two times daily; Lithium Carbonate 300 mg, one capsule two times daily; Polyethylene Glycol 3350, one capful in the morning; Levothyroxine 75 mcg, one tablet daily; Benzoyl Peroxide 5%, wash face daily and Vitamin D2 1.25 mg, one capsule two times a

Provider's Plan of Correction (handwritten): RBC Healthcare Manager will review the MAR on a monthly basis to be sure that all medication is listed on the MAR and that

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V 118	Continued From page 6 week. -The October 2019 MAR had blank boxes on 10/31 for Divalproex Sodium ER 500 mg, Risperidone 4 mg, Chlorpromazine 200 mg, Lithium Carbonate 300 mg, Polyethylene Glycol 3350, Levothyroxine 75 mcg, Benzoyl Peroxide 5% and Vitamin D2 1.25 mg. Interview with staff #2 on 12/9/19 confirmed: -The facility staff failed to keep the MAR current for client #1. Interview with the Support Staff on 12/9/19 revealed: -He was not sure why there were blank boxes on client #1's October MAR. -He thought staff possibly forgot to sign off on the October MAR. -He confirmed the facility staff failed to keep the MAR current for client #1. 3. The following is evidence facility staff failed to record administered medications immediately. a. Review on 12/9/19 of client #2's record revealed: -Admission date of 11/26/18. -Diagnoses of Schizoaffective Disorder-Bipolar Type, Post Traumatic Stress Disorder, Alcohol Use-in remission, Hyperthyroidism, Ptosis, Anemia and Morbidly Obese. -Physician's order dated 10/18/19 for Senna 8.8 mg, one tablet at bedtime. Physician's order dated 12/13/18 for Levothyroxine 150 mcg, one tablet in the morning. -Physician's order dated 12/11/18 for Clonazepam 1 mg, one tablet two times daily; Prazosin 5 mg, one capsule at bedtime; Clozapine 50 mg, one tablet at bedtime.	V 118	It is given. Manager will review MAR on a monthly basis for errors and discuss with staff as needed 1/10/20 RBC staff will review MAR on a monthly basis to be sure all the medications are listed. RBC manager will review the MARs on a monthly basis and be sure all the	

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V 118	Continued From page 7	V 118	the MARs are there for each client and placed in a separate binder for storage	1/1/20

-There was no evidence of an October 2019 MAR for the above administered medications.

b. Review on 12/9/19 of client #3's record revealed:
-Admission date of 2/1/16.
-Diagnoses of Depression, Morbid Obesity, Chronic Rhinitis and Vitamin D Deficiency.
-Physician's order dated 8/21/19 for Fluoxetine HCL 40 mg, one capsule in the morning; Risperidone 2 mg, one tablet two times daily; Lorazepam 1 mg, one tablet three times daily as needed; Tri-Sprintec, one tablet daily; Calcium 600 mg, one tablet daily; Cetirizine HCL 10 mg, one tablet at bedtime and Lisinopril 20 mg, one tablet two times daily.
-Physician's order dated 5/16/19 for Vitamin D3 5,000 units, one capsule daily.
-There was no evidence of an October 2019 MAR for the above administered medications.

Interview with staff #2 on 12/9/19 revealed:
-Clients' #2 and #3 did get their medications in October 2019.
-Staff had completed the October 2019 MAR's for clients' #2 and #3.
-He has not sure where those October 2019 MAR's were located.
-He confirmed the facility staff failed to record administered medications immediately.

Interview with the Support Staff on 12/9/19 revealed:
-He knew staff completed October 2019 MAR's for clients' #2 and #3.
-The October 2019 MAR's for clients' #2 and #3 were misplaced.
-He confirmed the facility staff failed to record administered medications immediately.

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V 119	Continued From page 8	V 119		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation, record review and interviews the facility staff failed to dispose of prescription medications in a manner that guards against diversion or accidental ingestion affecting	V 119	RBC Healthcare Manager will review the medication in the med cart on a monthly basis. During that time Manager will remove any expired medication for residents. Manager will also contact the pharmacy for medication that is current. 2/1/20	

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V 119	Continued From page 9 one of three clients (#1). The findings are: Review on 12/9/19 of client #1's record revealed: -Admission date of 3/8/18. -Diagnoses of Schizoaffective Disorder, Huntington's Disease, Multiple Sclerosis, Hypothyroidism, Hyperlipidemia and Vitamin D Deficiency. -Physician's order dated 7/1/19 for Polyethylene Glycol 3350, one capful in the morning. -The December 2019 MAR revealed client #1 was administered the above medication. Observation on 12/9/19 at approximately 9:05 AM of the medication area revealed: -The container of Polyethylene Glycol 3350 for client #1 expired May 30, 2019. Interview with staff #2 on 12/9/19 revealed: -Client #1 was administered the Polyethylene Glycol 3350 most days. -He did not realize the Polyethylene Glycol 3350 for client #1 had expired. -He confirmed the facility staff failed to ensure medications were disposed of in a manner that guards against diversion or accidental ingestion. Interview with the Support Staff on 12/9/19 confirmed: -The facility staff failed to ensure medications were disposed of in a manner that guards against diversion or accidental ingestion.	V 119		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the	V 121	RBC heathcare manager will be sure that the pharmacy will	

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V 121	Continued From page 10 governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to obtain drug reviews every six months for three of three clients (#1, #2 and #3) who received psychotropic drugs. The findings are: a. Review on 12/9/19 of client #1's record revealed: -Admission date of 3/8/18. -Diagnoses of Schizoaffective Disorder, Huntington's Disease, Multiple Sclerosis, Hypothyroidism, Hyperlipidemia and Vitamin D Deficiency. -Physician's order dated 7/1/19 for Divalproex Sodium ER 500 mg, two tablets daily; Risperidone 4 mg, one tablet two times daily; Chlorpromazine 200 mg, one tablet two times daily; Chlorpromazine 100 mg, one tablet daily as needed; Lithium Carbonate 300 mg, one capsule two times daily and Alprazolam 0.25 mg, one tablet three times daily as needed. -The December 2019 MAR revealed client #1 was administered the above medications. -There was a six months psychotropic drug review for client #1 dated 2/16/19. -There was no evidence of a current six months	V 121	Conduct a medication review on residents charts every six months. Manager will work with the pharmacy to ensure review is conducted on set dates. RBC will maintain the results of the review in the facility.	2/7/20

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V 121	Continued From page 11 psychotropic drug review for client #1. b. Review on 12/9/19 of client #2's record revealed: -Admission date of 11/26/18. -Diagnoses of Schizoaffective Disorder-Bipolar Type, Post Traumatic Stress Disorder, Alcohol Use-in remission, Hyperthyroidism, Ptosis, Anemia and Morbidly Obese. -Physician's order dated 12/3/19 for Trazodone HCL 100 mg, one tablet at bedtime and Clozapine 50 mg, one tablet in the morning and four tablets at bedtime. -Physician's order dated 12/11/18 for Clonazepam 1 mg, one tablet two times daily. -The December 2019 MAR revealed client #2 was administered the above medications. -There was a six months psychotropic drug review for client #2 dated 2/16/19. -There was no evidence of a current six months psychotropic drug review for client #2 c. Review on 12/9/19 of client #3's record revealed: -Admission date of 2/1/16. -Diagnoses of Depression, Morbid Obesity, Chronic Rhinitis and Vitamin D Deficiency. -Physician's order dated 8/21/19 for Fluoxetine HCL 40 mg, one capsule in the morning; Risperidone 2 mg, one tablet two times daily and Lorazepam 1 mg, one tablet three times daily as needed. -The December 2019 MAR revealed client #3 was administered the above medications. -There was a six months psychotropic drug review for client #3 dated 2/16/19. -There was no evidence of a current six months psychotropic drug review for client #3. Interview with the Support Staff on 12/7/19	V 121		

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V 121	Continued From page 12 revealed: -He did not realize the six months drug review was not currents for clients' #1, #2 and #3. -He confirmed the six months psychotropic drug review was not completed for clients' #1, #2 and #3.	V 121		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service	V 536	RBC Healthcare will have all staff trained on alternatives to restrictive interventions. Manager will review the staff charts on an annual basis to be sure all the trainings are in the charts. Completion date 2/7/20	

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V 536	Continued From page 13 provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time.	V 536		

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V 536	Continued From page 14	V 536		

(i) Instructor Qualifications and Training Requirements:
(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain

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V 536	Continued From page 15 documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of four audited staff (the Support Staff) had training on the use of alternatives to restrictive interventions prior to providing services. The findings are: Review on 12/6/19 of the facility's personnel files revealed: -There was no specific date of hire for the Support Staff. -The Support Staff had no documentation of training on the use of alternatives to restrictive interventions.	V 536		

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V 536	Continued From page 16 Interview with the Support Staff on 12/6/19 revealed: -The facility used North Carolina Interventions Core Plus for training on the use of alternatives to restrictive interventions. -He normally did not do direct care with the group home clients. -He just recently started having more interactions with the clients. -He did some transport and medical appointments for the clients. -He confirmed he had no documentation of training on the use of alternative to restrictive intervention.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.	V 537	RBC Healthcare will have all staff trained in seculsion physical restraint and isolation time out. Manager will review the staff charts on a annual basis to be sure all the training are in the chart	

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V 537	Continued From page 17 (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and	V 537	Completion 2/7/20	

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

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V 537	Continued From page 19 course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.	V 537		

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V 537	Continued From page 20 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of four audited staff (the Support Staff) had training in the use of seclusion, physical restraints and isolation time-out. The findings are: Review on 12/6/19 of the facility's personnel files revealed: -There was no specific date of hire for the Support Staff. -The Support Staff had no documentation of training in the use of seclusion, physical restraints and isolation time-out. Interview with the Support Staff on 12/6/19 revealed: -The facility used North Carolina Interventions Core Plus for training in the use of seclusion, physical restraints and isolation time-out. -He normally did not do direct care with the group home clients. -He just recently started having more interactions with the clients. -He did some transport and medical appointments for the clients. -He confirmed he had no documentation of training in the use of seclusion, physical restraints and isolation time-out.	V 537		