| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C A. BUILDING: | | (X3) DATE SURVEY COMPLETED |
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| | | MHL046-038 | B. WING | | 02/04/2020 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STATE | E, ZIP CODE | • |
| | | 415 EAST | HOLLOMAN AVE | | |
| REHOBO | TH COUNSELING SERVI | CES AHOSKIE | , NC 27910 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE COMPLETE |
| V 000 | INITIAL COMMENTS | | V 000 | | |
| | An annual survey was 2020. Deficiencies w | s completed on February 4, ere cited. | | | |
| | categories: 10A NCAC 27G .1400 | d for the following service Day Treatment for Children Emotional or Behavioral | | | |
| | Summer Developmer Children with or at Ris | | | | |
| | 10A NCAC 27G .4400 Intensive Outpatient F | | | | |
| V 113 | 27G .0206 Client Rec | ords | V 113 | | |
| | individual admitted to contain, but need not (1) an identification fa (A) name (last, first, n (B) client record numl (C) date of birth; (D) race, gender and (E) admission date; (F) discharge date; (2) documentation of developmental disabi diagnosis coded acco (3) documentation of assessment; (4) treatment/habilitat | all be maintained for each the facility, which shall be limited to: ce sheet which includes: niddle, maiden); per; marital status; mental illness, lities or substance abuse ording to DSM IV; the screening and ion or service plan; | | | |
| | (5) emergency inform | ation for each client which | | | |

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

TITLE (X6) DATE

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | , | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| | | MHL046-038 | B. WING | | 02/04/2020 | , |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | • | |
| REHOBO | TH COUNSELING SERVI | CES 415 EAST H | HOLLOMAN A' NC 27910 | /ENUE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPI | LETE |
| V 113 | sudden illness or acci and telephone number physician; (6) a signed statemer responsible person greemergency care from (7) documentation of (8) documentation of (9) if applicable: (A) documentation of diagnosis according to of Diseases (ICD-9-C (B) medication orders (C) orders and copies (D) documentation of administration errors (b) Each facility shall relative to AIDS or rel only in accordance with | to be contacted in case of dent and the name, address or of the client's preferred of the client or legally reanting permission to seek a hospital or physician; services provided; progress toward outcomes; physical disorders of International Classification M); collected of the contact of the contact of the contact of the client of the client's progress toward outcomes; physical disorders of International Classification M); collected of the contact of the contact of the contact of the contact of the client's preferred outcomes; physical disorders of International Classification M); collected outcomes of the contact of the contact of the contact of the client's preferred outcomes; physical disorders of the client's physical disorders of the client's physical disorders outcomes; physical disorders of the client's physical disorders outcomes; physical disorders | V 113 | | | |
| | failed to maintain doc provided and docume | ew and interview, the facility umentation of services entation of progress toward ormer clients (FC #1 and | | | | |
| | revealed: FC #1: - admission - diagnoses: | ecords for FC #1 and FC #2 date: uncertain Attention Deficit r (ADHD), combined type, D) | | | | |

Division of Health Service Regulation

STATE FORM 6899 Q0UT11 If continuation sheet 2 of 12

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE SURVEY COMPLETED | |
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| | | MHL046-038 | B. WING | | 02/04/2020 | |
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| NAME OF P | ROVIDER OR SUPPLIER | | DRESS, CITY, STA | | | |
| REHOBO1 | TH COUNSELING SERVICE | CES | HOLLOMAN A' , NC 27910 | VENUE | | |
| | 0.18.844.574.075 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE | |
| V 113 | Continued From page | 2 | V 113 | | | |
| | - no docume or progress toward ou activities provided him program FC #2: - admission of a diagnoses: - a treatment of a treatment of a treatment of activities provided him program During an interview of activities provided him program During an interview of activities provided him program During an interview of activities provided him program - she currently die of her programs - FC #1 only attered of her programs - FC #1 only attered of her programs - FC #2 attended in April and May, 2019 - both clients attered suspended from schoon of the same she was also the private practice armeetings - she had the same practice as they practice as they practive and activities provided him programs - she had the same practice as they practive as they practive and activities provided him programs - attention of the programs of | date: uncertain ADHD, Conduct DO I plan dated 8/1/19 Intation of services provided Itcomes for FC #2 for In by the day treatment In 2/4/20, the Licensee Id not have any clients in any Inded the program 4 time in Inter, 2019 Interpretation of the program of the | | | | |
| | - she would ensu done when clients we | re documentation would be re admitted again | | | | |
| V 536 | 27E .0107 Client Right. | its - Training on Alt to Rest. | V 536 | | | |
| | 10A NCAC 27E .0107 | TRAINING ON | | | | |

Division of Health Service Regulation

STATE FORM 6899 Q0UT11 If continuation sheet 3 of 12

Division of Health Service Regulation

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | | | A. BOILDING. | | |
| | | MHL046-038 | B. WING | | 02/0 | 4/2020 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AL | ODRESS, CITY, STA | TE, ZIP CODE | | |
| REHOBO | TH COUNSELING SERVI | CES 415 EAST | T HOLLOMAN A | /ENUE | | |
| | | AHOSKIE | E, NC 27910 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETE DATE |
| V 536 | Continued From page | e 3 | V 536 | | | |
| | ALTERNATIVES TO INTERVENTIONS (a) Facilities shall im practices that emphasto restrictive intervent (b) Prior to providing disabilities, staff incluemployees, students demonstrate compete completing training in other strategies for crwhich the likelihood or injury to a person oproperty damage is person of the provider agencies based on state compete compliance and demograthered. (d) The training shall include measurable testing (vertical behavior) on those of the measurable testing (vertical behavior) on those of the measurable testing (vertical behavior) on those of the provider wishes to enthe Division of MH/DI Paragraph (g) of this (g) Staff shall demonfollowing core areas: (1) knowledge people being served; (2) recognizing behavior; (3) recognizing | plement policies and size the use of alternatives tions. services to people with ding service providers, or volunteers, shall ence by successfully communication skills and reating an environment in if imminent danger of abuse with disabilities or others or revented. It is shall establish training retencies, monitor for internal constrate they acted on data the competency-based, rearning objectives, written and by observation of objectives and measurable re passing or failing the training must be completed der periodically (minimum ming that the service reploy must be approved by D/SAS pursuant to | | | | |

Division of Health Service Regulation

STATE FORM 6899 Q0UT11 If continuation sheet 4 of 12

Division of Health Service Regulation

| DIVISION | n Health Service Regu | ialion | _ | | | |
|------------|------------------------------|---|----------------------------|--|-------------|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE S | |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLE | TED |
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| | | | B WING | | | |
| | | MHL046-038 | B. WING | | 02/0 | 4/2020 |
| NAME OF PE | ROVIDER OR SUPPLIER | STRFFT AD | DRESS, CITY, STA | TE. ZIP CODE | | |
| | | | HOLLOMAN A | | | |
| REHOBOT | TH COUNSELING SERVICE | CES | | VLINOL | | |
| | | AHUSKIE | , NC 27910 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
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| | | | + | · | | |
| V 536 | Continued From page | e 4 | V 536 | | | |
| | disabilities; | | | | | l |
| | • | or building positive | | | | l |
| | | or building positive | | | | l |
| | relationships with pers | | | | | l |
| | () | cultural, environmental and | | | | l |
| | - | that may affect people with | | | | l |
| | disabilities; | | | | | |
| | | the importance of and | | | | l |
| | | n's involvement in making | | | | |
| | decisions about their | life; | | | | |
| | (7) skills in asse | essing individual risk for | | | | |
| | escalating behavior; | | | | | |
| | (8) communicat | tion strategies for defusing | | | | l |
| | and de-escalating pot | entially dangerous behavior; | | | | |
| | and | | | | | |
| | (9) positive beh | avioral supports (providing | | | | |
| | • • | n disabilities to choose | | | | |
| | activities which direct | | | | | |
| | behaviors which are u | | | | | |
| | (h) Service providers | | | | | |
| | | al and refresher training for | | | | |
| | | ai and renesher training to | | | | l |
| | at least three years. | tion shall include: | | | | l |
| | ` ' | tion shall include: | | | | l |
| | | ated in the training and the | | | | l |
| | outcomes (pass/fail); | de que de que addesse de de | | | | |
| | ` ' | here they attended; and | | | | l |
| | (C) instructor's | | | | | l |
| | • • | n of MH/DD/SAS may | | | | l |
| | | ocumentation at any time. | | | | l |
| | (i) Instructor Qualification | ations and Training | | | | l |
| | Requirements: | | | | | l |
| | (1) Trainers sha | all demonstrate competence | | | | l |
| | by scoring 100% on to | esting in a training program | | | | l |
| | aimed at preventing, r | reducing and eliminating the | | | | |
| | need for restrictive int | - | | | | l |
| | (2) Trainers sha | all demonstrate competence | | | | |
| | by scoring a passing | | | | | l |
| | instructor training pro | | | | | l |
| | (3) The training | | | | | |
| | | oclude measurable learning | | | | |

Division of Health Service Regulation

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Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | |
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| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED |
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| | | MHL046-038 | B. WING | | 02/04/2020 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | |
| | | 415 EAST | HOLLOMAN A | VENUE | |
| REHOBO | TH COUNSELING SERVI | CES AHOSKIE | , NC 27910 | | |
| (V4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID. | PROVIDER'S PLAN OF CORRECTIO | N (X5) |
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| V 536 | Combined Francisco | - F | V 536 | , | |
| V 530 | V 536 Continued From page 5 | | V 536 | | |
| | objectives, measurable testing (written and by | | | | |
| | | ior) on those objectives and | | | |
| | measurable methods | to determine passing or | | | |
| | failing the course. | | | | |
| | | t of the instructor training the | | | |
| | service provider plans | | | | |
| | | sion of MH/DD/SAS pursuant | | | |
| | to Subparagraph (i)(5 | , | | | |
| | | instructor training programs | | | |
| | | not limited to presentation of: | | | |
| | | ng the adult learner; | | | |
| | , , | r teaching content of the | | | |
| | course; (C) methods fo | r evaluating trainee | | | |
| | performance; and | r evaluating trainee | | | |
| | · · | ion procedures. | | | |
| | | all have coached experience | | | |
| | | ogram aimed at preventing, | | | |
| | | ting the need for restrictive | | | |
| | _ | one time, with positive | | | |
| | review by the coach. | , · | | | |
| | | all teach a training program | | | |
| | | reducing and eliminating the | | | |
| | need for restrictive in | terventions at least once | | | |
| | annually. | | | | |
| | (8) Trainers sha | all complete a refresher | | | |
| | instructor training at le | | | | |
| | (j) Service providers | | | | |
| | | al and refresher instructor | | | |
| | training for at least th | _ | | | |
| | \ <i>\</i> | entation shall include: | | | |
| | | ated in the training and the | | | |
| | outcomes (pass/fail); | | | | |
| | ` ' | vhere attended; and | | | |
| | (C) instructor's | | | | |
| | ` ' | n of MH/DD/SAS may | | | |
| | · · · · · · · · · · · · · · · · · · · | nis documentation any time. | | | |
| | (k) Qualifications of (| | | | |
| | l (1) Coaches sh | nall meet all preparation | 1 | | |

Division of Health Service Regulation

STATE FORM 6899 Q0UT11 If continuation sheet 6 of 12

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | MHL046-038 | B. WING | | 02/04/2020 | |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| REHOBO | TH COUNSELING SERVI | CES | HOLLOMAN A' , NC 27910 | VENUE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE COMPLETE | |
| V 536 | the course which is be (3) Coaches show competence by computation the trainer instruction of the competence of the compe | iner. Itall teach at least three times being coached. Itall demonstrate letion of coaching or lection. Itall be the same preparation Italian and interview, the facility example ternatives to restrictive leting are: Italian are: Italia | V 536 | DEFICIENCY) | | |
| | | | | | | |
| V 537 | 27E .0108 Client Righ | nts - Training in Sec Rest & | V 537 | | | |

Division of Health Service Regulation

STATE FORM 6899 Q0UT11 If continuation sheet 7 of 12

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | MHL046-038 | B. WING | | 02/0 | 4/2020 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| DEHOBO. | TH COUNSELING SERVI | CES 415 EAST | HOLLOMAN A | VENUE | | |
| KEHOBO | I II COUNSELING SERVI | AHOSKIE | NC 27910 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE |
| V 537 | Continued From page | e 7 | V 537 | | | |
| | ISOLATION TIME-OU (a) Seclusion, physic time-out may be emp been trained and hav competence in the property to these procedures. Staff authorized to emprocedures are retrained to procedures are retrained to procedures are retrained to procedures are retrained to providing disabilities whose treating the providers, emprocedures shall composerized providers, emproviders shall not use the training is completed demonstrated. (c) A pre-requisite for demonstrating composerized for restrictive (d) The training shall include measurable testing (when the provider plans to determine the course. (e) Formal refresher by each service provider plans to empthe Division of MH/DI Paragraph (g) of this | cal restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives. Facilities shall ensure that aploy and terminate these ned and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including aployees, students or olete training in the use of estraint and isolation time-out se interventions until the and competence is a raking this training is effence by completion of a reducing and eliminating e interventions. The competency-based, earning objectives, written and by observation of objectives and measurable e passing or failing the training must be completed der periodically (minimum ning that the service oloy must be approved by D/SAS pursuant to Rule. The growing programs shall include, | | | | |

Division of Health Service Regulation

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Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STA | TE, ZIP CODE | |
| REHORO | TH COUNSELING SERVI | CES 415 EAS | T HOLLOMAN A | /ENUE | |
| KEHODO | TH GOONGEEING GERVI | AHOSKII | E, NC 27910 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETE |
| V 537 | 7 Continued From page 8 | | V 537 | | |
| V 337 | (1) refresher in the use of restrictive is (2) guidelines of (understanding immir others); (3) emphasis or rights and dignity of a concepts of least rest incremental steps in a (4) strategies for of restrictive interventions which in assessment and more psychological well-because of restraint through restrictive intervention (6) prohibited profession (7) debriefing simportance and purpor (8) documentation of initiat least three years. (1) Documentation (A) who particip outcomes (pass/fail); (B) when and work (C) instructor's (2) The Division review/request this documents: (1) Trainers show yearing 100% on the aimed at preventing, need for restrictive in (2) Trainers show the strictive in (3) Trainers show the strictive in (4) Trainers show the strictive in (5) Trainers show the strictive in (6) Trainers show the strictive in (7) Trainers show t | formation on alternatives to interventions; on when to intervenement danger to self and in safety and respect for the all persons involved (using crictive interventions and an intervention); or the safe implementation tions; emergency safety include continuous intoring of the physical and ing of the client and the safe indicated in the duration of the in; procedures; itrategies, including their includes and tion methods/procedures. In shall maintain in all and refresher training for it in shall include: in the training and the indicated in the training and the includes attended; and in an of MH/DD/SAS may becomentation at any time. In all demonstrate competence esting in a training program reducing and eliminating the | V 337 | | |

Division of Health Service Regulation

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| Division of Health Service Regulation | | | | | _ |
|---------------------------------------|---|--|---------------------|--|------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | (X2) MULTIPLE CONSTRUCTION | |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLETED |
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| | | MHL046-038 | B. WING | | 02/04/2020 |
| NAME OF D | DOVIDED OD CURRUED | OTDEE: | TADDDECC CITY CTA | TE 7/D CODE | |
| NAME OF PI | ROVIDER OR SUPPLIER | | TADDRESS, CITY, STA | | |
| REHOBO1 | TH COUNSELING SER | RVICES | AST HOLLOMAN A | VENUE | |
| | | AHOS | KIE, NC 27910 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (- / |
| PREFIX TAG | , | NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | |
| | | | | DEFICIENCY) | |
| V 537 | Camtinuad Francis | 0 | V 537 | | |
| V 531 | Continued From pa | age 9 | V 557 | | |
| | teaching the use of | f seclusion, physical restraint | | | |
| | and isolation time-out.(3) Trainers shall demonstrate competenceby scoring a passing grade on testing in an | | | | |
| | | | | | |
| | | | | | |
| | instructor training p | _ | | | |
| | | ing shall be | | | |
| | | I, include measurable learning | | | |
| | | able testing (written and by | | | |
| | | avior) on those objectives and | | | |
| | | ds to determine passing or | | | |
| | failing the course. | ant of the instructor training the | | | |
| | ` ' | ent of the instructor training the ans to employ shall be | | | |
| | • | ivision of MH/DD/SAS pursuant | | | |
| | to Subparagraph (j | | | | |
| | | ole instructor training programs | | | |
| | | ot be limited to, presentation | | | |
| | of: | | | | |
| | | nding the adult learner; | | | |
| | | for teaching content of the | | | |
| | course; | • | | | |
| | (C) evaluation | on of trainee performance; and | | | |
| | (D) documen | tation procedures. | | | |
| | (7) Trainers | shall be retrained at least | | | |
| | , | onstrate competence in the use | | | |
| | | cal restraint and isolation | | | |
| | - | ed in Paragraph (a) of this | | | |
| | Rule. | ala all la a commandio desira a dife | | | |
| | (8) Trainers : | shall be currently trained in | | | |
| | | shall have coached experience | | | |
| | , , , | of restrictive interventions at | | | |
| | | n a positive review by the | | | |
| | coach. | | | | |
| | (10) Trainers | shall teach a program on the | | | |
| | , , | terventions at least once | | | |
| | annually. | | | | |
| | (11) Trainers | shall complete a refresher | | | |
| | instructor training at least every two years. | | | | |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | MHL046-038 | B. WING | | 02/04/2 | 020 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, STA | TE, ZIP CODE | | |
| REHOBO | TH COUNSELING SERVI | CES | HOLLOMAN A | VENUE | | |
| | | AHOSKIE, | NC 27910 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE C | (X5) COMPLETE DATE |
| V 537 | training for at least the (1) Documenta (A) who particip outcome (pass/fail); (B) when and w (C) instructor's (2) The Division review/request this do (I) Qualifications of C (1) Coaches sh requirements as a tra (2) Coaches sh times, the course whi | shall maintain al and refresher instructor ree years. tion shall include: ated in the training and the where they attended; and name. n of MH/DD/SAS may ocumentation at any time. coaches: tall meet all preparation iner. liall teach at least three ch is being coached. tall demonstrate letion of coaching or iction. shall be the same | V 537 | | | |
| | failed to ensure 2 of 2 #1) were trained in se and isolation time-out Review on 2/4/20 of p - staff #1 - hire date 1 - no docume seclusion, physical re - Licensee: - hire date 1 - no docume | ew and interview, the facility 2 staff (Licensee and staff eclusion, physical restraint . The finding are: Dersonnel records revealed:: 4/19 entation of training in straint and isolation time-out | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED | |
|--|--|---|------------------------------|---|------------------|--------------------------|
| | | MHL046-038 | B. WING | | 02 | /04/2020 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STA | TE, ZIP CODE | | |
| REHOBO1 | TH COUNSELING SERVI | CES | T HOLLOMAN A' E, NC 27910 | VENUE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| V 537 | During an interview o reported they had tro Seclusion, physical re | n 2/4/20, the Licensee uble finding a trainer in | V 537 | DEFICIENCY) | | |
| | | | | | | |

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