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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on June 2, 2021. The complaint was unsubstantiated (intake #NC00177675). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and	V 105		

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

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to implement written standards that assure applicable standards of practice amidst the COVID-19 (Coronavirus-Disease-2019) pandemic. The findings are: Review on 6/1/21 of the facility's COVID-19 posted undated policy and procedure revealed: -"Provided respiratory hygiene supplies (e.g., hand hygiene agents, tissues, face masks, trash receptacle) throughout the facility for use by residents, staff, and visitors." Review on 6/2/21 State of North Carolina signed Executive Order No. 215 Lifting COVID-19 Restrictions to Reflect New Public Health Recommendations dated 5/14/21 revealed: -"Section 2. Face Coverings...In addition, Face Coverings are also required in the setting listed in Section 3 of this Executive Order below...Section 3. Restriction on Certain Businesses and Operations...3.3 Health Care Settings. a. Infection Prevention in Health Care Facilities. All residents, workers, and visitors in health care settings including hospitals, outpatient healthcare setting, Long Term Care ("LTC") Facilities, skilled nursing facilities ("SNF"), and intermediate care facilities for individual with intellectual disabilities ("ICFIID"), must follow the requirements in the CDC (Centers for Disease Control and Prevention) Healthcare Infection and Prevention Control Recommendations in Response to COVID-19 Vaccinations..." Review on 6/2/21 of the North Carolina Department of Health and Human Services LTC May 6th Webinar frequently asked questions to	V 105		

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providers revealed:
-On pages 2-4 Personal Protection Equipment (PPE) Questions/Social Distancing.
-Question #17: "Universal PPE should still be worn by staff when doing resident care activities-essentially any time staff is with residents. If all residents are vaccinated, the residents do not need masks or to be 6 feet apart, but the staff still need to wear face masks."

Observation while in the facility on 6/1/21 from approximately 9:00am to 1:00pm, no staff or client had worn a face mask during the onsite visit.

Interview on 6/1/21 staff #1 stated:
-Staff complete temperature checks when clients and staff enter and leave the facility.
-Staff wore a mask when outside the facility with clients.

Interview on 6/2/21 staff #2 stated:
-Staff were not required to wear mask but she chose to wear a mask at the facility.

Interview on 6/2/21 staff #3 stated:
-It was not required for staff to wear mask in the facility.

Interview on 6/2/21 the House Manager stated:
-It was optional for staff to wear mask in the facility.
-Mask were required when clients and staff left the facility.
-No clients had been vaccinated against COVID-19.
-She had not been sure of any staff vaccination status.

This deficiency constitutes a re-cited deficiency

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V 105	Continued From page 4 and must be corrected within 30 days.	V 105		
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 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.	V 118		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to administer medications as ordered by a physician and failed to keep MARs current affecting three of three clients (#1, #2 and #3) and one of four audited staff (#1) failed to demonstrate competency with medication administration. The findings are:

Finding #1
Review on 06/01/21 of client #1's record revealed:
-11 year old male.
-Admission date of 02/05/21.
-Diagnoses of Depressive Mood Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Unspecified Anxiety Disorder, Oppositional Defiant Disorder (ODD) and Post Traumatic Stress Disorder (PTSD).

Review on 6/1/21 and 6/2/21 of client #1's signed physician orders revealed:
2/5/21
-Divalproex (treats seizures) 250 milligrams (mg) - take 3 tablets at bedtime.
-Aripiprazole (anti-psychotic) - take one tablet at bedtime.
-Concerta (treats ADHD) 36mg - take one tablet daily.

3/30/21
-Melatonin Gummies (sleep aid) 5mg - one at bedtime.
-Zyrtec (Cetirizine-treats allergies) 10mg - once daily.

Review on 6/1/21 and 6/2/21 of client #1's March 2021 thru May 2021 MARs revealed the following

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V 118	Continued From page 6 blanks: March 2021 -Divalproex - 3/29/21 thru 3/31/21. -Aripiprazole - 3/29/21 thru 3/31/21. -Concerta - 3/2/21, 3/3/21 and 3/25/21. April 2021 -Divalproex - 4/15/21, 4/22/21 and 4/30/21. -Concerta - 4/4/21, 4/29/21 and 4/30/21. -Aripiprazole - 4/30/21. May 2021 -Divalproex - 5/1/21, 5/2/21, 5/13/21, 5/29/21 thru 5/31/21. -Aripiprazole - 5/1/21, 5/3/21 and 5/29/21 thru 5/31/21. -Melatonin - 5/1/21, 5/2/21, 5/22/21 and 5/29/21 thru 5/31/21. -Zyrtec - 5/1/21 thru 5/5/21, 5/24/21 thru 5/31/21. -Concerta - 5/1/21 thru 5/5/21 and 5/29/21 thru 5/31/21. Interview on 6/1/21 client #1 stated he received his medications daily as ordered. Finding #2: Review on 6/1/21 of client #2's record revealed: -14 year old male. -Admission date of 2/23/21. -Diagnoses of ADHD and Intermittent Explosive Disorder. Review on 6/1/21 and 6/2/21 of client #2's signed physician orders revealed: 5/6/21 -Lithium Carbonate (treats Bipolar) 150mg - take one at bedtime. -Oxcarbazepine (treats seizure disorders) 15mg give 3 at bedtime.	V 118		

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V 118	Continued From page 7 2/23/21 -Quetiapine (antipsychotic) 100mg - take one tablet daily. -Docusate Sodium (stool softner) 100mg - take one tablet at bedtime. -Sertraline (anti depressant) 50 mg - take once daily. -Vitamin D2 (treats vitamin deficiency) 1.25mg - take one capsule twice a week. Review on 6/1/21 and 6/3/21 of client #2's March 2021 thru May 2021 revealed the following blanks: March 2021 -Quetiapine - 3/19/21 and 3/29/21 thru 3/31/21. -Docusate Sodium - 3/18/21 thru 3/23/21 and 3/29/21 thru 3/31/21. -Sertraline - 3/2/21, 3/3/21 and 3/31/21. -Vitamin D2 - 3/2/21 thru 3/31/21. April 2021 -Quetiapine - 4/1/21 4/5/21, 4/6/21 and 4/30/21. -Docusate Sodium - 4/1/21 thru 4/30/21. -Sertraline - 4/4/21 and 4/30/21. -Vitamin D2 - 4/1/21 thru 4/30/21. May 2021 -Lithium - 5/1/21 thru 5/7/21, 5/11/21, 5/14/21 and 5/29/21 thru 5/31/21. -Docusate Sodium - 5/1/21 thru 5/31/21.. -Quetiapine - 5/1/21 thru 5/8/21 and 5/29/21 thru 5/31/21. -Oxcarbazepine - 5/1/21 thru 5/9/21 and 5/29/21 thru 5/31/21. -Sertraline - 5/1/21 thru 5/7/21 and 5/29/21 thru 5/31/21. -Vitamin D2 - 5/1/21 thru 5/31/21. Interview on 6/1/21 client #2 stated he received his medications daily.	V 118		

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V 118	Continued From page 8 Finding #3 Review on 6/1/21 of client #3's record revealed: -13 year old male. -Admission date of 9/2/20. -Diagnoses of ODD, Conduct Disorder, PTSD and ADHD. Review on 6/1/21 and 6/2/21 of physician orders for client #3 revealed: 9/17/20 -Divalproex 250mg, 1 tablet every morning (treat psychiatric conditions). -Guanfacine 4mg, 1 tablet every night at bedtime (treat ADHD). 9/25/20 -Methylphenidate 30mg , 1 capsule every morning (treat ADHD). 3/22/21 -Melatonin 3mg, 1 tablet at bedtime. Review on 6/1/21 of client #3's MARs from March 11, 2021 to May 2021 revealed the following blanks: March 2021 -Divalproex - 3/25/21. -Guanfacine - 3/29/21. -Methylphenidate - 3/25/21. -Melatonin - 3/29/21. April 2021 -Divalproex - 4/4/21, 4/29/21, 4/30/21. -Guanfacine - 4/10/21. -Methylphenidate - 4/4/21, 4/29/21, 4/30/21. -Melatonin - 4/15/21, 4/28/21, 4/29/21. May 2021 -Divalproex - 5/1/21 thru 5/5/21, 5/12/21, 5/29/21	V 118		

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thru 5/31/21.
-Guanfacine - 5/1/21, 5/2/21, 5/29/21 thru 5/31/21.
-Methylphenidate - 5/1/21 thru 5/5/21, 5/29/21 thru 5/31/21.
-Melatonin - 5/1/21, 5/2/21, 5/4/21, 5/6/21, 5/7/21, 5/29/21 thru 5/31/21.

Interview on 6/1/21 client #3 stated he received his medications daily.

Finding #4
Review on 6/2/21 of staff #1's record revealed:
-Original hire date 9/10/19.
-Most recent rehire date 5/11/21.
-Medication administration training completed 10/20/19.
-"Coaching Documentation" for staff #1 dated 4/5/20 for Immediate Termination. "Occurrence. Medication Error, Not following medication Protocol, not informing staff and management of error. I was informed that on 3/12/2020 you administered the wrong medication to a client. I was also informed that after you discovered the error you then administered the correct medication to the client which resulted in the client having been given to much medication which was a medication overdose. I was also informed by the incoming shift that you did not informed them of what had occurred and that the client informed them that you then told the him not to tell anyone. There have been other issues concerning your performance such as sleeping on the job which was previously addresses. Staff Comments: Recommended Action: Because you administered the wrong medication to the client indicate that you were not following medication administration protocol. Because you did not inform management or the incoming shift of what had occurred and told the client not to tell anyone,

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V 118	Continued From page 10 it appears that you were trying to hide the error which could have resulted in harm to the client. For this occurrence you are terminated immediately." Signed by staff #1 and Director/Licensee on 4/6/20. Interview on 6/1/21 staff #1 stated: -He had administered medications. -There was always enough medications for clients. -Clients received their medication daily. Interview on 6/1/21 and 6/2/21 the House Manager stated: -Clients had received their medications daily. -There was an error on the MARs with each month ending on the 28th day. -Staff used the medication count sheet and initialized it to show medications were administered. -Staff #1 had not administered medications since he was rehired. -Staff #1 had not been retrained in medication administration since his rehire. -Staff #1 was unable to attend the last medication administration training on 5/15/21 because he had another job. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency has been cited 6 times since the original cite on 10/15/18 and must be corrected within 30 days.	V 118		
V 121	27G .0209 (F) Medication Requirements	V 121		

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V 121	Continued From page 11 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the 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 review and interviews, the facility failed to ensure one of three audited clients (#3) had a psychotropic drug regimen review at least every six months. The findings are: Review on 6/1/21 of client #3's record revealed: -13 year old male. -Admission date of 9/2/20. -Diagnoses of Oppositional Defiant Disorder, Conduct Disorder, Post Traumatic Stress Disorder and Attention Deficit Hyperactivity Disorder (ADHD). -No current drug regimen review. Review on 06/01/21 of client #3's current drug regimen revealed: -Divalproex DR 250mg, 1 tablet every morning (treat psychiatric conditions). -Guanfacine ER 4mg, 1 tablet every night at	V 121		

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V 121	Continued From page 12 bedtime (treat ADHD). -Methylphenidate 30mg ER, 1 capsule every morning (treat ADHD). -Melatonin 3mg, 1 tablet at bedtime (sleep aid). Interview on 6/2/21 the House Manager stated: -No psychotropic review had been done for client #3.	V 121		
V 295	27G .1703 Residential Tx. Child/Adol - Req. for A P 10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS (a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1). (b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following: (1) management of the day to day day-to-day operations of the facility; (2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and (3) participation in service planning meetings. This Rule is not met as evidenced by:	V 295		

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V 295	Continued From page 13 Based on record review and interview the facility failed to have at least one full-time direct care staff who meets or exceeds the requirements of an Associate Professional (AP). The findings are: Review on 6/1/21 of the client/staff census revealed no AP listed. Interview on 6/1/21 and 6/2/21 the House Manager stated: -The facility did not have an AP. -The position had been vacant for a couple months. -The Licensee advertised for the AP position, but it had not been filled. Interview on 6/2/21 the Licensee stated: -She was in the process of seeking applicants for the AP position. -She had advertised for the position, but it had not been filled. -She had a difficult time filling the position.	V 295		
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	V 367		

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V 367	Continued From page 14 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 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	V 367		

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V 367	Continued From page 15 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; (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 interview, the facility failed to report a critical incident to the home and host Local Management Entity (LME) as required. The findings are:	V 367		

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V 367	Continued From page 16 Review on 06/01/21 of the North Carolina Incident Response Improvement System (IRIS) website revealed no level II incident report for an unplanned restrictive intervention implemented on client #1 for 04/12/21. Review on 06/01/21 of client #1's record revealed: -11 year old male. -Admission date of 02/05/21. -Diagnoses of Depressive Mood Disorder, Attention Deficit Hyperactivity Disorder, Unspecified Anxiety Disorder, Oppositional Defiant Disorder and Post Traumatic Stress Disorder. -Treatment Plan updated on 03/17/21. -Treatment plan did not authorize planned usage of restrictive interventions. Review on 06/01/21 of a facility North Carolina Department of Health and Human Services incident report for client #1 revealed: -Date of Incident: 04/12/21. -Time of Incident: 5:00pm -Description: See attached page. -Staff involved: Staff #2 and staff #3. -"Progress Note Date 4/12/21 On 4/21/21 [Client #1] begin displaying negative behavior about 5:00pm because he wasn't getting his way. Member began kicking the walls in his room, destroying his room and tearing up his clothes. Member started walking around the facility and into office. When member went into the office, he grabbed the phone. Staff prompted member several times to give the phone back and he refused. Staff had to take the phone away from member. Member began displaying negative behavior towards staff as well as using profanity. Member began bullying staff and acted like he was going to hit her several times. Staff had to	V 367		

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V 367	Continued From page 17 push member away several times and had to restrain him. Member was not trying to calm down. He continued to show negative behavior. Staff escorted member to his room so that he could calm down..." Interview on 06/02/21 the Licensee stated: -She understood an unplanned use of a restrictive intervention for clients should result in a Level II IRIS report. -She would ensure correct documentation was completed. This deficiency has been cited 3 times since the original cite on 10/24/19 and must be corrected within 30 days.	V 367		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used;	V 521		

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V 521	Continued From page 18 (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the necessary documentation was in the client record when a restrictive intervention was utilized affecting one of three clients (#1). The findings are: Review on 06/01/21 of client #1's record revealed: -11 year old male. -Admission date of 02/05/21. -Diagnoses of Depressive Mood Disorder, Attention Deficit Hyperactivity Disorder, Unspecified Anxiety Disorder, Oppositional Defiant Disorder and Post Traumatic Stress Disorder. -No documentation of required information when a restrictive intervention was implemented on 04/12/21 for client #1.	V 521		

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V 521	Continued From page 19 Review on 06/01/21 of a facility North Carolina Department of Health and Human Services incident report for client #1 revealed: -Date of Incident: 04/12/21. -Time of Incident: 5:00pm -Description: See attached page. -Staff involved: Staff #2 and staff #3. -"Progress Note Date 4/12/21 On 4/21/21 [Client #1] begin displaying negative behavior about 5:00pm because he wasn't getting his way. Member began kicking the walls in his room, destroying his room and tearing up his clothes. Member started walking around the facility and into office. When member went into the office, he grabbed the phone. Staff prompted member several times to give the phone back and he refused. Staff had to take the phone away from member. Member began displaying negative behavior towards staff as well as using profanity. Member began bullying staff and acted like he was going to hit her several times. Staff had to push member away several times and had to restrain him. Member was not trying to calm down. He continued to show negative behavior. Staff escorted member to his room so that he could calm down..." Interview on 06/02/21 the Licensee stated: -She understood an unplanned use of a restrictive intervention for clients should result in a Level II IRIS report. -She understood restrictive interventions required documentation on the type of restraint, time, debriefing and methods of intervention. -She would ensure correct documentation was completed.	V 521		

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V 536	Continued From page 20	V 536		
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 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;	V 536		

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V 536	Continued From page 21 (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. (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	V 536		

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V 536	Continued From page 22 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 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.	V 536		

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V 536	Continued From page 23 (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, observation and interviews the facility failed to assure two of four audited paraprofessional staff (#1, #10) were trained and demonstrated competency in Alternatives to Restrictive Interventions. The findings are: Review on 6/2/21 of staff #1's record revealed: -Original hire date 9/10/19. -Most recent rehire date 5/11/21. -Nonviolent Crisis Intervention Training (NCI) completed on 10/3/20. -"Coaching Documentation" for staff #1 dated 11/11/20 Immediate Termination "Occurrence: Child Abuse On Tuesday November 10th 2020, [Qualified Professional (QP)] the QP received a call from the manager [previous staff] about issues with a consumer. [QP] entered the facility and heard you raised voice. When he spoke with	V 536		

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V 536	Continued From page 24	V 536		

the client, the client accused you of cursing at him and threatening him. Which you denied doing. The client requested that the camera be reviewed and that we would be able to see how you were treating them This action prompted [QP] to review the camera. On camera, you are seen and heard using profanity towards the client. You are heard telling the client that you would body slam his a**....You were antagonizing the client and arguing with the client. This incident went on for at least thirty minutes. The client stated that his all started because the client's asked if they can go outside...Your ability to de-escalate yourself or the clients is a serious issue that we addressed with you before. You were moved to a different home with younger clients in hopes that you would be able to interact with them in a more professional manner. We have provided you with additional training NCI plus as well as clients rights training. Training The purpose of the NCI training is to teach you how to de-escalate the clients. You have not demonstrated the ability to utilize use any of the techniques taught to you. You were removed from the other home, [sister facility] schedule for the same type incident that was investigated by DHHS (Department of Health and Human Services). IN your attempt to restrain the client, you ended up almost fighting the client. Your coworker attempted to intercede and defuse the situation and you refused. Because you interact with the clients in a manner that is verbally abusive, threatening and is traumatic which is not helpful towards their treatment and needs, you are being terminated immediately."
-There was no documentation in staff #1's record to show he had been trained and demonstrated competency on Alternative to Restrictive Interventions since his rehire.

Review on 6/2/21 of the facility's personnel

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V 536	Continued From page 25 records revealed: -No record for staff #10. -No documentation she was trained in Alternatives to Restrictive Interventions prior to providing services. Observation on 6/1/21 at approximately 9:25am revealed: -Staff #10 arrived at facility to shadow staff prior to orientation. -The House Manager arrived at the facility. Interview on 6/1/21 staff #1 stated: -He recently had to place client #1 in a physical restraint. Interview on 6/1/21 staff #10 stated: -It was her first day at the facility. -She was at the facility to shadow staff. Interview on 6/1/21 and 6/2/21 the House Manager stated: -She was not sure about staff #1's previous termination. -Staff #10 was only at the facility to shadow. -She had been trained in NCI and staff #1 had been trained in NCI. Interview on 06/02/21 the Licensee stated she understood all staff were required to have training in alternatives to restrictive intervention prior to providing services.	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	V 537		

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V 537	Continued From page 26 (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. (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	V 537		

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V 537	Continued From page 27 (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 (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	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-159	A. BUILDING: _____ B. WING _____	R 06/02/2021

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V 537	Continued From page 28 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 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.	V 537		

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V 537	Continued From page 29 (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. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility to assure two of five audited staff were trained (#1, #10) or demonstrated competency in seclusion, physical restraint and isolation time-out. The findings are: Review on 6/2/21 of staff #1's record revealed: -Original hire date 9/10/19. -Most recent rehire date 5/11/21. -Nonviolent Crisis Intervention Training (NCI) completed on 10/3/20. -"Coaching Documentation" for staff #1 dated 11/11/20 Immediate Termination "Occurrence: Child Abuse On Tuesday November 10th 2020, [Qualified Professional (QP)] the QP received a call from the manager [previous staff] about issues with a consumer. [QP] entered the facility	V 537		

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V 537	Continued From page 30 and heard you raised voice. When he spoke with the client, the client accused you of cursing at him and threatening him. Which you denied doing. The client requested that the camera be reviewed and that we would be able to see how you were treating them This action prompted [QP] to review the camera. On camera, you are seen and heard using profanity towards the client. You are heard telling the client that you would body slam his a**....You were antagonizing the client and arguing with the client. This incident went on for at least thirty minutes. The client stated that his all started because the client's asked if they can go outside...Your ability to de-escalate yourself or the clients is a serious issue that we addressed with you before. You were moved to a different home with younger clients in hopes that you would be able to interact with them in a more professional manner. We have provided you with additional training NCI plus as well as clients rights training. Training The purpose of the NCI training is to teach you how to de-escalate the clients. You have not demonstrated the ability to utilize use any of the techniques taught to you. You were removed from the other home, [sister facility] schedule for the same type incident that was investigated by DHHS (Department of Health and Human Services). IN your attempt to restrain the client, you ended up almost fighting the client. Your coworker attempted to intercede and defuse the situation and you refused. Because you interact with the clients in a manner that is verbally abusive, threatening and is traumatic which is not helpful towards their treatment and needs, you are being terminated immediately." -There was no documentation in staff #1's record to show he had been re-trained and demonstrated competency on seclusion, physical restraint and isolation time since his rehire.	V 537		

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V 537	Continued From page 31 Review on 6/2/21 of the facility's personnel records revealed: -No record for staff #10. -No documented training in seclusion, physical restraint and isolation time-out prior to providing services. Observation on 6/1/21 at approximately 9:25am revealed: -Staff #10 arrived at facility to shadow staff prior to facility orientation. -The House Manager arrived at the facility. Interview on 6/1/21 staff #1 stated: -He recently had to place client #1 in a physical restraint. Interview on 6/1/21 staff #10 stated: -It was her first day at the facility. -She was at the facility to shadow a staff member. Interview on 6/1/21 and 6/2/21 the House Manager stated: -She was not sure about staff #1's previous termination. -Staff #10 was only at the facility to shadow staff prior to beginning work. -She had been trained in NCI and staff #1 had been trained in NCI in the event a physical restrictive intervention was needed. Interview on 06/02/21 the Licensee stated she understood all staff were required to receive training in seclusion, physical restraint and isolation time prior to providing services.	V 537		