PRINTED: 10/01/2021 FORM APPROVED

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL097-065 B. WING 09/30/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 NORTHVIEW PLAZA MOUNTAIN HEALTH SOLUTIONS - NORTH WILKESBO NORTH WILKESBORO, NC 28659 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual survey was completed on 9/30/2021. Deficiecies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .3600 Outpatient Opioid Treatment and 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program. The current census was 542. V 235 27G .3603 (A-C) Outpt. Opiod Tx. - Staff V 235 The Clinic Director immediately 11/04/2021 post open position and begins 10A NCAC 27G .3603 STAFF recruiting process as soon as (a) A minimum of one certified drug abuse counselor or certified substance abuse counselor there is a vacancy. Due to the to each 50 clients and increment thereof shall be COVID-19 pandemic and being in on the staff of the facility. If the facility falls below a rural area there have not been this prescribed ratio, and is unable to employ an applicants for the open position. individual who is certified because of the Clinic Director will continue to unavailability of certified persons in the facility's recruit on indeed, social media. hiring area, then it may employ an uncertified person, provided that this employee meets the and local newspaper. We will certification requirements within a maximum of 26 reach out to local colleges and try months from the date of employment. to obtain interns. The Office (b) Each facility shall have at least one staff Manager is also a certified member on duty trained in the following areas: counsleor and the clinic director is (1)drug abuse withdrawal symptoms; and a licensed cousnelor and can see (2)symptoms of secondary complications to drug addiction. patients as needed. There is an (c) Each direct care staff member shall receive interview scheduled on 11/9/2021 continuing education to include understanding of for a potential CADC. the following: (1)nature of addiction; (2)the withdrawal syndrome; (3)group and family therapy; and (4)infectious diseases including HIV, sexually transmitted diseases and TB. Division of Health Service Regulation (X6) DATE

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

If continuation sheet 1 of 8

DHSR - Mental Health

NOV 0 8 2021

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LTIPLE CONSTRUCTION (X3)		X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		COMP	LETED	
		MHL097-065	B. WING		00/	30/2021	
					1 09/	30/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, S	FATE, ZIP CODE			
MOUNTAI	N HEALTH SOLUTIONS -	- NORTH WILKESB(THVIEW PLAZ				
			WILKESBORO,				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5)	
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				DEFICIENCY)			
V 235	Continued From page	1	V 235				
	Continuou i rom page		1 200				
	This Rule is not met a	as avidanced by:		A waiver has been submitt	od		
		ews and interviews, the				11/04/2021	
		e a minimum of one certified		to Section Chief of DHSR			
	drug abuse counselor			Counselor #1. The Clinical			
	abuse counselor to ea			Supervisor, Greg Moon, wi	11		
		ere on the staff of the facility;		obtain a waiver for all			
		d staff (Counselor #1 (C#1))		clinicians prior to 26 month	s if		
		rements within 26 months		intern status is not obtained			
	from the date of emplo	syment. The findings are:			7,007		
	D : 0/00/0004						
		of the facility's client and					
	staff census reports re		İ				
		nts being served by the pioid Treatment component					
	of the facility's services						
	- There were 10 Couns						
	facility.	sciois working at the					
	Review on 9/30/2021 of	of C#1's employee file					
	revealed:						
	- Hire date: 10/12/2015	5					
		or the Certified Alcohol nad					
		ntial on 12/15/2015, and					
	again on 1/11/2021.					1	
	- Sne nad not yet rece	ived full credential status.					
	Interview on 9/30/2021	1 with C#1 revealed:					
		ng as a Counselor at the				- 1	
	facility for approximate					- 1	
		en 54 clients for "a pretty				- 1	
	good while."					- 1	
	- She was registered a	s a CSAC-R (Certified				- 1	
	Substance Abuse Coul	nselor - the certification title					
	prior to the Certification	n Board changing the name					
	on 1/1/2020).						
	- She had not passed t	the test to obtain full	1				
	certification yet.		1			I	

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If continuation sheet 2 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		MHL097-065	B. WING		09/	30/2021
	ROVIDER OR SUPPLIER N HEALTH SOLUTIONS	NORTH WILKESB(200 NORT	DRESS, CITY, ST HVIEW PLAZ ILKESBORO,	A		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 235	- She would probably the coming months. Interview on 9/30/202 revealed: - His caseload was cues the comment of	be re-taking the test within 1 with Counselor #2 rrently 55 clients. the staff turnover which had aseloads. 60 clients while a set to Covid-19. It tried to keep his caseload 1 with the Clinic Director for certification at the end on period. and had not yet passed the sing obtaining a waiver to working beyond the expired equired by rule for ounselor on staff were also	V 235			
V 536	Int. 10A NCAC 27E .0107 ALTERNATIVES TO R INTERVENTIONS (a) Facilities shall impl	lement policies and ze the use of alternatives ons.	V 536			

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If continuation sheet 3 of 8

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<u> </u>	COMPL	_ETED	
					1		
		MHL097-065	B. WING		09/:	30/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
MOUNTA	N HEALTH COLUTIONS	200 NORT	THVIEW PLAZ	A			
WOUNTAI	N HEALTH SOLUTIONS	NORTH WILKESBE NORTH W	/ILKESBORO,	NC 28659			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
IAG	NEGOLATORT ON E	SO DENTI TING IN ONMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	AIE	DATE	
V 536	Continued From page	. 3	V 536				
, 000			1 000				
		ding service providers,	1	Safety Care training was		10/26/2021	
	employees, students		1	completed on 10/26/2021 for	rall		
	demonstrate compete			new staff.		3	
		communication skills and eating an environment in		Clinic Director will schedule		F)	
		f imminent danger of abuse		annual training in Feburary 2	022		
		with disabilities or others or		The Regional Director will of			
	property damage is pr			training monthly for all new h			
		shall establish training					
	based on state compe	etencies, monitor for internal		to ensure everyone is trained			
	compliance and demo	instrate they acted on data		prior to providing patient care	€.		
	gathered.				-		
	(d) The training shall be						
	include measurable le						
		ritten and by observation of					
		jectives and measurable					
	methods to determine course.	passing or failing the					
		raining must be completed					
		der periodically (minimum					
	annually).	, (
	(f) Content of the train	ning that the service					
	provider wishes to em	ploy must be approved by					
	the Division of MH/DD						
	Paragraph (g) of this F						
		strate competence in the					
	following core areas:	and condensate address (C.C.)					
		nd understanding of the					
	people being served; (2) recognizing a	and interpreting human					
	behavior;	and interpreting numan					
		the effect of internal and					
		may affect people with					
	disabilities;			*			
		building positive				- 1	
	relationships with pers						
		cultural, environmental and					
	~	that may affect people with					
	disabilities;						

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T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	
	MHL097-065	B. WING	***************************************	09/	30/2021
ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
N HEALTH SOLUTIONS -	NORTH WILKESB(
					_
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE
Continued From page	4	V 536			
(6) recognizing assisting in the person decisions about their I (7) skills in asse escalating behavior; (8) communicat and de-escalating pot and (9) positive beh means for people with activities which directly behaviors which are u (h) Service providers documentation of initial at least three years. (1) Documentat (A) who participal outcomes (pass/fail); (B) when and w (C) instructor's recommended (2) The Division review/request this doe (i) Instructor Qualifical Requirements: (1) Trainers shat by scoring 100% on the aimed at preventing, recommended for restrictive interestrictive interestrictive interestrictive interestrictive interestrictive interestrictive interestrictives, measurable observation of behavior measurable methods to	the importance of and n's involvement in making ife; essing individual risk for ion strategies for defusing entially dangerous behavior; avioral supports (providing disabilities to choose y oppose or replace nsafe). shall maintain all and refresher training for ion shall include: ated in the training and the here they attended; and name; of MH/DD/SAS may cumentation at any time. tions and Training Il demonstrate competence esting in a training program educing and eliminating the erventions. Il demonstrate competence rade on testing in an an an aram. shall be clude measurable learning estesting (written and by or) on those objectives and	V 536			
(4) The content of the instructor training the service provider plans to employ shall be					
	ROVIDER OR SUPPLIER N HEALTH SOLUTIONS SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page (6) recognizing assisting in the persor decisions about their I (7) skills in assessed escalating behavior; (8) communicat and de-escalating pot and (9) positive behameans for people with activities which directly behaviors which are u (h) Service providers documentation of initiat at least three years. (1) Documentat (A) who participate outcomes (pass/fail); (B) when and w (C) instructor's r (2) The Division review/request this do (i) Instructor Qualificat Requirements: (1) Trainers shat by scoring 100% on the aimed at preventing, reneed for restrictive interestrictive interestrictive interestrictive interestrictive interestrictive interestrictives, reasurable observation of behavior measurable methods to failing the course. (4) The content of the content of the course. (5) The content of the course of the course. (6) The content of the course. (7) The content of the course. (8) The content of the course. (9) The content of the course. (1) The content of the course.	MHL097-065 ROVIDER OR SUPPLIER N HEALTH SOLUTIONS - NORTH WILKESBC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 (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 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	ROVIDER OR SUPPLIER NHEALTH SOLUTIONS - NORTH WILKESB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 (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 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 a passing grade 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	PROVIDER OR SUPPLIER MHL097-065 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 200 NORTHVIEW PLAZA NORTH WILKESBRON, NC 28659 SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 4 (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; (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 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 by scoring a passing grade on testing in an instructor training program. (3) The 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.	TOURISH OR SUPPLIER MHL097-065 STREET ADDRESS, CITY, STATE, JP CODE 200 NORTH-YILEW PLAZA NORTH-WILKESBORO, NC 28559 SLUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING IMPORMATION) COntinued From page 4 (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). (1) 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 by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-by secretain program aimed at preventing, reducing and eliminating the need for restrictive interventions. (3) The training shall be competency-by secretain program aimed at preventing pr

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DIVISION	or riealth Service Regu	liation					
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	A. BUILDING:		COMPLETED	
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1		MHL097-065	B. WING			10010001	
		WINE097-003			09	/30/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	FATE, ZIP CODE			
		200 NO	RTHVIEW PLAZ	A			
MOUNTAI	N HEALTH SOLUTIONS	NORTH WILKESBO NORTH	WILKESBORO,	NC 28659			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)	
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				DEFICIENCY	<u> </u>		
V 536	Continued From page	5	V 536				
		ion of MH/DD/SAS pursuant					
	to Subparagraph (i)(5						
		instructor training programs					
		not limited to presentation of:					
		ng the adult learner;	1				
		teaching content of the					
	course;						
*		evaluating trainee					
	performance; and						
		on procedures.					
		all have coached experience					
		ogram aimed at preventing,					
		ing the need for restrictive					
	interventions at least of	one time, with positive					
	review by the coach. (7) Trainers sha	all teach a training program					
		educing and eliminating the					
		erventions at least once					
	annually.	erverilloris at least office					
		Il complete a refresher					
	instructor training at le						
	(j) Service providers s						
	7	al and refresher instructor					
	training for at least thre						
	•	ntation shall include:	1				
		ated in the training and the					
	outcomes (pass/fail);	and the daming and the					
		here attended; and		1			
	(C) instructor's r						
	70 70	of MH/DD/SAS may					
		s documentation any time.					
	(k) Qualifications of C	the control of the co					
		all meet all preparation					
1	requirements as a train						
	and the first and a result of the control of the second	all teach at least three times					
	the course which is be						
9		all demonstrate	1				
	competence by comple						
	train-the-trainer instruc						
train-the-trainer instruction.		1					

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	COMPLETED	
		MHL097-065	B. WING			20/2004	
		WHE097-005			[09/	30/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
MOUNTAL	N HEALTH COLUTIONS	NORTH WILLIAMS 200 NORT	HVIEW PLAZA	A			
WOONTAL	N HEALTH SOLUTIONS	NORTH W	ILKESBORO,	NC 28659			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 536	Continued From page	6	V 536				
V 330	Continued From page	. 0	V 550				
	(I) Documentation sh	all be the same preparation					
	as for trainers.						
			1				
			Ī				
	This Rule is not met a	as evidenced by:					
	Based on record review	w and interviews, the					
	facility failed to ensure	staff completed Training		1			
	on Alternatives to Res	trictive Interventions prior to					
	providing services for	1 of 1 Registered Nurse					
	(RN). The findings are	:					
	Review on 9/30/2021	of the RN personnel record					
	revealed:						
	-A hire date of 8/24/20	021;					
	-No documentation that	at Training on Alternatives					
	to Restrictive Interven	tions had been completed.					
		1 with the RN revealed she	1				
	was unable to rememb						
		Alternatives to Restrictive					
	Interventions.						
	Interview on 9/30/202	I with the Nursing					
	Supervisor revealed:	Est configuration of the second				1	
	-The RN was recently						
	completed the Training					1	
	Restrictive Intervention					- 1	
		ed to complete the training				- 1	
	in October 2021;					- 1	
		t the training was required				I	
	to be completed by sta	aff prior to providing				- 1	
	services.					- 1	
						1	
	Interview on 9/30/2021	with the Clinical Director				- 1	

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		MHI 007 065	B. WING			
		MHL097-065	1		<u> 09/</u>	30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
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MOUNTAI	N HEALTH SOLUTIONS	- NORTH WILKESR(VILKESBORO,			
1001110 1001	0.11.11.11.11.11		all le Consu			
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				DEFICIENCY)		
V 500	0 " 15	-	1,,,,,,			
V 536	Continued From page	2 7	V 536			
	revealed:					
		hired and had not yet				
	completed the Trainin					
	Restrictive Intervention					
		ed to complete the training				
	in October 2021;	complete the training				
		e first scheduled training				
	since COVID-19 bega					
		the training was required to				
		prior to providing services.				
	or completed by clair	prior to providing dervices.				
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