STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

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LAVERNE'S HAVEN RESIDENTIAL SERVICES, LLC	811 OAKWOOD DRIVE EDEN, NC 27288

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V 000	INITIAL COMMENTS A complaint survey was completed on 10/28/21. The complaints were unsubstantiated (Intake #NC00181790, #NC00181926, and #NC00182154). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability	V 000		
V 106	27G .0201 (A) (8-18) (B) 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: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for facility areas including special client activity areas; and	V 106		

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V 106	Continued From page 1 (18) client grievance policy, including procedures for review and disposition of client grievances. (b) Minutes of the governing body shall be permanently maintained. This Rule is not met as evidenced by: Based on record reviews, observation, and interviews, the facility failed to implement their written policy regarding incident reporting of any incident or unusual occurrence. The findings are: Review on 10/12/21 of the facility's policy and procedure manual revealed: -"Incident Reporting: All incidents and unusual occurrences involving the facility, clients, or staff shall be reported to the Qualified Professional (QP) and Executive Director immediately according to this procedure ... All incidents will be documented on incident reporting forms ..." Finding #1: Client #1's Absent Without Leave (AWOL) on 4/26/21 Review on 10/4/21 of Client #1's record revealed: -Date of Admission was 9/14/20. -Diagnoses of Brain Injury; Neurocognitive Disorder due to brain injury; Aphasia. -Review of treatment plan dated 10/6/20 revealed no goals related to AWOL. Review of Incident Response Improvement System (IRIS) on 10/4/21 & 10/11/21 revealed: -No incident reports of Client #1's AWOL incident Review on 10/13/21 of the facility's level 1	V 106		

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V 106	Continued From page 2	V 106		

incident reports from 1/2/21 to 10/13/21 revealed:
-No incident reports for the AWOL of Client #3 on 4/26/21

Review on 10/11/21 of an EMS (emergency medical services) report provided by Client #1's Guardian dated 4/25/21 revealed:
-Client #1 was reported missing on 4/25/21 and was found by Law Enforcement (LE) on 4/26/21.
-Client #1 declined medical care.
-Client #1 stated " ...he left due to them (facility staff) being violent."
-Client #1 was returned to the facility by LE.

Interview on 10/4/21 with Client #1 revealed:
-He admitted to running away from the facility once on an unknown date.

Interview on 10/11/21 with Client #1's Guardian revealed:
-Client #1 ran away from the facility in April 2021 and was gone overnight.
-LE had been called to report Client #1 had left the facility.
-Client #1 was picked up the next day by an off-duty police officer.
-Client #1 refused medical care and was transported back to the facility by LE.

Interview on 10/11/21 with the QP revealed:
-She had been informed Client #1 had left the facility on 4/25/21.
-She did not know Client #1 had been gone overnight.
-She thought Client #1 had only been AWOL for 15-20 minutes.
-The Director informed her of the situation and told her Client #1 had been found and brought back after 15-20 minutes.
-She had not been informed as to the reason why

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V 106	Continued From page 3 Client #1 left the facility. Interview on 10/12/21 with the Director revealed: -Client #1 left the facility AWOL "around 7 pm on Sunday evening (4/25/21)." -The guardian did not want LE to be notified Client #1 had left the facility. -He informed the Guardian he would have to notify LE. -He did not specify why he did not complete an incident report. -He should have filled out an incident report. Finding #2: Client #3's bruises on 4/19/21 Review on 10/12/21 of Client #3's record revealed: -Admission date was 3/21/18 -Diagnoses of Prater-Willi Syndrome; Intellectual Disability- Moderate; Perseveration/Obsessive Compulsive Disorder (Symptoms related to Prater-Willi Syndrome) -Progress notes dated 4/19/21 to 5/9/21 revealed: -Client #3 was on a home visit with his Guardian from 4/9/21 to 4/19/21. -A 4/19/21 progress note written by Staff #1 revealed Client #3 returned from his home visit at 12:30 pm and " ...returned with bruises on his leg, chest, and his butt when [Client #3] left from the facility to do his home visit [Client #3] had no marks or bruises on his body ..." -A 4/19/21 progress note written by the Director revealed Client #3's Guardian called the Director on an unspecified date and informed him that she had noticed the bruises on 4/10/21; the Guardian sent photos of the bruises to the Director on an unspecified date; that Staff #1 told the Director that she had assisted Client #3 with dressing 4/9/21 prior to the home visit and he did not have any marks on his body at that time; and Client #3	V 106		

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V 106	Continued From page 4	V 106		

stated he did not know how he got the bruises.
-There was no documentation of an assessment or evaluation to determine the cause, age, or severity of the bruises.

Reviews on 10/4/21 and 10/11/21 of the Incident Response Improvement System (IRIS) revealed:
-There were no level 2 or 3 incidents reported by the facility since 4/1/21.
-There were no incident reports for Client #3 at any time.

Review on 10/13/21 of the facility's level 1 incident reports dated 1/2/21 to 10/13/21 revealed:
-No incident reports related to Client #3's Guardian having reported that she found bruises on Client #3's body during his 4/9/21 to 4/19/21 home visit.
-There was no documentation of an investigation to determine the cause of Client #3's bruises.
-There was no documentation of development or implementation of corrective measures to prevent further injuries of unknown origin.

Review on 10/11/21 of photographs provided by Client #3's Guardian revealed:
-The photos were not time-stamped.
-The photos did not show Client #3's face.
-A yellowish-brown colored bruise located to the side of a nipple, which was approximately ½ inch in diameter.
-A yellowish-brown colored bruise located above the other nipple, which was approximately 1-2 inches in diameter.
-A circular, brownish-yellow-colored bruise was located on the outer mid-thigh area and was approximately 2-3 inches in diameter.
-A crescent-shaped bruise of similar color was adjacent to the circular bruise and was

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V 106	Continued From page 5 approximately 5 inches long. -2 reddish areas, that resemble open sores, approximately ¼ - ½ inches in diameter near the bruised area. -4 discolored areas that were pinkish-brown and approximately ¼ - ½ inches in diameter, also near the larger bruise on the thigh. Interview on 10/4/21 with Client #3 revealed: -He was unable to provide any clear information about bruises he sustained in April of 2021. Interview on 10/11/21 with Client #3's Guardian revealed: -Client #3 had greenish-yellow bruises when he came home for a visit in April 2021. -She took photos of the bruises while Client #3 was on the home visit. -Staff #1 "got real snippy with me" when she sent photos of the bruises to the Director. -She could not remember the exact date that the pictures were taken or when she sent to the Director. -She was certain that someone "shoved" Client #3. Interviews on 10/4/21 & 10/12/21 with Staff #1 revealed: -She never had conversations with Client #3's Guardian. -The Director was the facility staff responsible for contacting Guardians. -When Client #3 left for his home visit on 4/9/21, he had shorts on. -Full body checks under the clothes were not done but no marks were seen on Client #3. -When Client #3 returned from his home visit, he had "something" (bruises) on his leg and arm. -Client #3 reported that he did not know where the bruises came from.	V 106		

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V 106	Continued From page 6 -Client #3 was on his home visit for over a week. -She reported the bruising to the Director. Interview on 10/8/21 with Staff #4 revealed: -When an incident occurred, there was a special form that was supposed to be completed by facility staff. -Incident reports were forwarded to the Director once they are completed. Interview on 10/8/21 with Staff #5 revealed: -The Director would be the first person she would call if there were an incident, such as an unknown injury. Interviews on 10/11/21 and 10/13/21 with the QP revealed: -She did not have regular contact with Clients' Guardians unless there was an incident to report to them. -The Director or residential staff were usually the ones who contacted Guardians. -She had not received any incident reports to review since approximately February of 2021. -The Director was typically the person who informed her of incidents at the facility. -She was not aware of the bruises that had been on Client # 3's chest and leg on 4/19/21. -She had not seen the photographs of the bruises on Client #3. -Typically, facility staff would notify her of injuries of unknown origin, and she would go to the facility to investigate further. -She had not been aware of the injury on Client #4's temple or the bruises on his stomach. Interviews from 10/4/21 to 10/13/21 with the Director revealed: -Client #3 returned to the facility from a 10-day home visit on 4/19/21.	V 106		

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V 106	Continued From page 7	V 106		

-Client #3's Guardian had informed him the day before Client #3 returned on 4/19/21 Client #3 had multiple bruises on his body.
-Client #3's Guardian sent him photos of the bruises.
-He had checked with Staff #1 and she had informed him Client #3 did not have any bruises when he left for his home visit on 4/9/21.
-Client #3 was accident-prone.
-The bruising must have occurred while he was on the home visit.
-It was difficult to get clear answers from Client #3 about how he sustained injuries.
-By the time Client #3 returned from the home visit, the bruising was almost healed.
-He had not completed an incident report to document Client #3's injuries.
-"Chalk that up to me because I talked to [Client #3's Guardian] and she was fine with it. She kept saying she was fine (with the conversation about the bruises). She thought he (Client #3) could have done it while he was at home. She can't follow up with him like the home (the facility) can."
-He did not remember if he had notified the QP of Client #3's injuries.
-Client #3 had made the statement his Guardian "beat" him in the past.
-He did not report Client #3's accusation against the Guardian to anyone.

Finding #3: Client #4's injuries (9/24/21)

Review on 10/4/21 of Client #4's record revealed:
-Date of Admission was 6/29/20.
-Diagnoses of Schizoaffective Disorder, Depressive Type; Intellectual Developmental Delay - Moderate; Autism Spectrum Disorder.
-A treatment plan dated 4/26/21 that revealed a history of "aggression and volatility" at previous residential placements that resulted in discharge

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V 106	Continued From page 8	V 106		

from placement, physical aggression towards staff and peers, throwing objects, property destruction and running away.
-Progress notes dated 9/22/21 through 9/24/21 revealed no documentation of any behavioral incidents or injuries.

Review on 10/13/21 of the facility's level 1 incident reports dated 1/2/21 to 10/13/21 revealed:
-No documentation of any injuries on Client #4's face or stomach.
-No documentation of any incidents of Client #4 breaking televisions.

Reviews on 10/4/21 and 10/11/21 of the Incident Response Improvement System (IRIS) revealed:
-There were no level 2 or 3 incidents reported by the facility since 4/1/21.

Review on 10/4/21 of the facility's staff schedule for September 21 revealed:
-Staff#1 worked from 8:00am to 4:00pm on 9/22/21 to 9/24/21.
-Staff #4 worked from 4:00pm to 12:00am on 9/22/21 to 9/24/21.
-Staff #5 worked from 12:00am to 8:00am on 9/22/21 to 9/23/21 and 8:00pm to 8:00am on 9/25/21.
-Staff #2 worked from 12:00am to 8:00am on 9/24/21.
-Staff #6 worked from 8:00am to 8:00pm on 9/25/21.
-The Director was not on the schedule to work a shift.

Observation at approximately 1:40pm on 10/4/21 of Client #4's face and stomach revealed:
-A reddened area approximately ¼ inch x ½ inch was present on the temple area on the left side of

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	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

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V 106	Continued From page 9	V 106		

his face.
-A yellowish bruise approximately 1/4-inch x 3 inches was located on the upper left quadrant of his stomach.
-7 other pale-yellow bruises ranging in size from approximately ¼ inch to 1 inch across his stomach.
-4 scratch-like reddened areas less than approximately ¼ inch long located within the bruised areas on the upper right quadrant of his stomach.

Interview on 10/4/21 with Client #4 revealed:
-The reddened area on his left temple was caused by Staff #1 having hit him with a belt on an unknown date.
-The Director had "beat" him by punching him in the stomach on an unknown date.

Interview on 10/7/21 with Client #4's Peer Support Specialist (PSS) revealed:
-He worked with Client #4 twice a week.
-On Wednesday, 9/22/21, Client #4 did not have any injuries visible.
-On Friday, 9/24/21, " ... His (Client #4's) face was bruised and he had a cut on his face ..."
-When he asked Staff #1 (on 9/24/21) about Client #4's facial injury, Staff #1 told the PSS she had to restrain Client #4 because he had an "episode."
- He and Client #4 had met with Client #4's Guardian on 10/1/21 .
-During that meeting, Client #4 reported the Director had hit him on the stomach.
-He had been surprised about that allegation because Client #4 had not told him about the Director hitting him when they talked on 9/24/21.

Interview on 10/7/21 with Client #4's Guardian revealed:

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V 106	Continued From page 10 -She and another Department of Social Services (DSS) staff had met Client #4 and Client #4's Peer Support Specialist on 10/1/21. -Client #4 had a "mark" on his temple. -Client #4 did not show her the bruises on his stomach because they were in a public place. -Client #4 had informed her the mark on his temple was caused by Staff #1 hitting him with a belt. -Client #4 reported the Director had punched him in the stomach. Interviews on 10/4/21 and 10/12/21 with Staff #1 revealed: -She thought the injury on Client #4's temple may have been caused by him bumping his head on a cabinet near the washing machine. -She was not sure when the injury happened. -She did not complete an incident report because she did not have to restrain Client #4. -When incidents occurred with facility clients, she completed an incident report and then gave it to the Director. -Incidents rarely occurred at the facility. -Client #4 never complained about his stomach hurting other than complaining of indigestion. Interview on 10/8/21 with Staff #2 revealed: -He had not noticed any injuries on Client #4's face when he worked on 9/24/21. -He did not know how Client #4 sustained bruising on his stomach. -If he had any concerns about injuries of unknown origins, he would notify the Director and do an incident report. Interview on 10/11/21 with Staff #4 revealed: -She did not know how or when Client #4 sustained an injury to his temple. -She had never completed a full body check on	V 106		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 106	Continued From page 11 Client #4. -She would not have known to look for a stomach injury on Client #4 because he did not complain of stomach pain. -The only time Client #4 had complained about hurting was when he told her he had an erection, so he threw a television of the floor on an unspecified date. -The incident had not occurred on her shift. -When incidents occurred in the facility, staff were supposed to fill out an incident report form and then send it to the Director. Interview on 10/8/21 with Staff #5 revealed: -She usually worked third shift, so only had limited contact with clients. -Client #4 slept with the covers over his head. -She had not noticed any injuries on Client #4's face. -If an incident occurred at the facility, she would call the Director and write an incident report. Interviews on 10/11/21 and 10/13/21 with the QP revealed: -She had not received any incident reports to review since approximately February of 2021. -Typically, facility staff would notify her of injuries of unknown origin, and she would go to the facility to investigate further. -She had not been aware of the injury on Client #4's temple or the bruises on his stomach. Interviews from 10/4/21 to 10/13/21 with the Director revealed: -On an unknown date, Client #4 had become sexually excited and broken a television. -Client #4 could have injured himself during that incident. -The Director did not know to look for a stomach injury on Client #4 because he did not complain	V 106		

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V 106	Continued From page 12 of any stomach pain. - He was not aware that Staff #1 had been accused of hitting Client #4 with a belt. - He was not aware that an allegation was made that he punched Client #4 in the stomach. -It had been his responsibility to complete the incident reports for Client #1's AWOL incident, Client #3's bruises, and Client #4's injuries. This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type B rule violation and must be corrected within 45 days.	V 106		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills;	V 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 110	Continued From page 13 (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews, observation, and interviews, 1 of 7 paraprofessional staff (the Director) failed to demonstrate knowledge, skill and abilities required by the population served. The findings are: Cross Reference: 10A NCAC 27G .0201 Governing Body Policies (V106) Based on record reviews, observation, and interviews, the facility failed to implement their written policy regarding incident reporting of any incident or unusual occurrence. Cross Reference: 131E-256. Health Care Personnel Registry (V132) Based on record reviews, observation and interviews, the facility failed to ensure that the Department was notified of all injuries of unknown source, and have evidence of investigations and make efforts to protect residents from harm while the investigations were in process affecting 2 of 4 clients (#3 and #4). Cross Reference: 10A NCAC 27G .5603 Operations (V291) Based on record reviews and interviews, the	V 110		

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V 110	Continued From page 14 facility failed to coordinate care between the facility and qualified professionals who are responsible for treatment/habilitation affecting 1 of 4 clients (#3). Cross Reference: 10A NCAC 27G. 0603 Incident Response Requirements for Category A and B Providers (V366) Based on observation, record reviews and interviews, the facility failed to attend to the health and safety needs of individuals, determining cause of incident, and developing and implementing corrective measures affecting 2 of 4 clients (#3 and #4). Review on 10/6/21 of the Director's record revealed: -Date of hire was 4/20/17 as the Director. -Education qualified him as a paraprofessional. -He was responsible for oversight of the facility. Interviews from 10/4/21 to 10/13/21 with the Director revealed: -He did not report Client #3's accusation against the Guardian to anyone. -He did not remember if he had notified the QP of Client #3's injuries. -He had not completed an incident report to document Client #3's injuries. -"Chalk that (not completing an incident report about Client #3's injuries) up to me because I talked to [Client #3's Guardian] and she was fine with it. She kept saying she was fine (with the conversation about the bruises). She thought he (Client #3) could have done it while he was at home. She can't follow up with him like the home (the facility) can." -He had not coordinated medical evaluation of Client #3's bruises because by the time Client #3 returned from the home visit, the bruising was	V 110		

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V 110	Continued From page 15 almost healed. -It had been his responsibility to complete the incident reports for Client #1's AWOL incident, Client #3's bruises, and Client #4's injuries. -It was his responsibility to complete incident reports and coordinate medical evaluation for clients when they had injuries of unknown origin. -He had not completed an investigation into the causes of Clients' #3 and #4's injuries. -He had not developed corrective measures to address obtaining medical assessment of injuries of unknown origin, investigating causes of injuries, and allegations of abuse and/or neglect. Review on 10/18/21 of the Plan of Protection (POP) dated 10/13/21 written by the Qualified Professional (QP) revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? 1. Laverne's Haven will ensure that all clients reside in a safe and therapeutic setting. 2. Laverne's Haven will employ professionals who are dedicated, compassionate, and understand client care, safety and abide by agency policies and procedures. 3. Laverne's Haven will develop compliance standards suitable for the agency and all stakeholders. 4. Laverne's Haven will establish a framework to evaluate employee compliance 5. Laverne's Haven will initiate or eliminate any concerns of abuse within the facility by any employee or client. 6. Laverne's Haven will provide a centralized compliance outlet. -Describe your plans to make sure the above happens. 1. Refresher training will be provided to all staff regarding client rights, restrictive interventions, de-escalation techniques and incident reporting.	V 110		

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V 110	Continued From page 16 This training will be completed and documented by November 1,2021 by [the QP]. 2. Laverne's Haven will ensure that all incident reports are completed in a timely manner according to local, state, and federal guidelines. 3. Laverne's Haven will ensure that all staff are trained in the use of statewide incident reporting system. (IRIS) (Incident Response Improvement System) 4. Laverne's Haven will ensure that appropriate medical treatment is sought and obtained for all clients, in the event medical care is necessary. In the event, that Laverne's Haven staff is unaware of any bruises, marks, etc., that appear on clients, medical treatment will be sought to determine possible cause and method of reporting. 5. Laverne's Haven staff will complete body checks on all residents weekly, and report any marks, bruises, or any unusual occurrences with client. Body check forms will be filed in client record for review. 6. Laverne's Haven will ensure that clients receive appropriate routine and preventive medical treatment with necessary professionals. Consultation forms will be completed on each visit and filed in client chart. Any findings or recommendations will be provided to the Qualified Professional for review. Services will be linked, arranged, and coordinated for client based upon visits and recommendations. 7. Laverne's Haven will employ an assistant director who meets the qualifications of Qualified Professional to assist in ensuring all local, state, and federal guidelines/rules are met and that facility remains in compliance. 8. Supervision for all staff will occur monthly, as opposed to quarterly, until further notice to ensure that staff are competent and knowledgeable	V 110		

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V 110	Continued From page 17 regarding client care, incident reporting, de-escalation techniques, and understanding the population served. 9. A community meeting (house meeting) will occur ASAP with clients and qualified professional to ensure that clients are aware of how to report and to whom to report any of their concerns. 10. All guardians and involved stakeholders will be sent information regarding Laverne's Haven's Corporate Compliance Program and the role of the Corporate Compliance Officer ([the QP]). This will be sent out by Monday, October l7 and annually. 11. Laverne's Haven will ensure that any staff that has been alleged to have abused, neglected, or exploited a client is immediately suspended while an internal investigation occurs. 12. The Qualified Professional will be included in all decision-making processes and the QP will perform regular agency performance reviews. The performance reviews will provide a dynamic indicator of whether Laverne's Haven has achieved intended outcomes. This will also assist in adjusting agency policies, as necessary." Review on 10/28/21 of the revised POP dated 10/28/21 and signed by the Director revealed: - Additional plans were added to the original POP as follows: -"What immediate action will the facility take to ensure the safety of the consumers in your care?... 7. Laverne's Haven will conduct an internal investigation, lead by the QP (the QP) for any repoded (reported) abuse of any client and/or for any reported known or unknown bruises on any client, B. Laverne's Haven will suspend any staff that has been accused of abuse towards any client until the internal	V 110		

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V 110	Continued From page 18 investigation has concluded. 9. Laverne's Haven will complete a Health Care Personnel Registry as well as an IRIS report for any known or unknown injuries of any client..." There were four clients residing in this facility. All the clients had extensive mental health and developmental disabilities, such as Schizoaffective Disorder, Intellectual Disability-Moderate, Prater-Willi Syndrome, Autism Spectrum and Traumatic Brain Injury. Clients had eloped from the facility, destroyed property, had injuries of unknown origin, and made allegations of abuse against a guardian and staff. These incidents were not documented and reported to the QP and oversight agencies. No assessment or evaluation was completed to determine the extent of injuries obtained from unknown origins. Internal investigations of the incidents to determine causes were not conducted and corrective measures had not been developed to address the incidents. The Director was responsible for oversight of incident reporting and response, as well as, coordination of care for the clients at the facility. The Director's failure to report, respond, investigate incidents, assess and evaluate injuries of unknown origin was detrimental to the health, safety, and welfare of the clients. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 110		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL	V 131		

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V 131	Continued From page 19 REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to access the Health Care Personal Registry (HCPR) prior to an offer of employment for 1 of 6 audited staff (#4). The findings are: Review on 10/6/21 of staff #4's record revealed: -Date of hire was 7/1/21 -HCPR check was accessed on 10/5/21 Interview on 10/12/21 with the Director revealed: -He was responsible for checking HCPR. -He generated a book for each employee. -He misplaced staff #4's HCPR check.	V 131		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:	V 132		

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V 132	Continued From page 20 a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews, observation and	V 132		

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V 132	Continued From page 21 interviews, the facility failed to ensure that the Department was notified of all injuries of unknown source, and have evidence of investigations and make efforts to protect residents from harm while the investigations were in process affecting 2 of 4 clients (#3 and #4). The findings are: Review on 10/12/21 of Client #3's record revealed: -Admission date was 3/21/18 -Diagnoses of Prater-Willi Syndrome; Intellectual Disability- Moderate; Perseveration/Obsessive Compulsive Disorder (Symptoms related to Prater-Willi Syndrome) -Progress notes dated 4/19/21 to 5/9/21 revealed: -Client #3 was on a home visit with his Guardian from 4/9/21 to 4/19/21. -A 4/19/21 progress note written by Staff #1 revealed that Client #3 returned from his home visit at 12:30 pm and " ...returned with bruises on his leg, chest, and his butt when [Client #3] left from the facility to do his home visit [Client #3] had no marks or bruises on his body ..." -A 4/19/21 progress note written by the Director revealed that Client #3's Guardian called the Director and informed him that she had noticed the bruises on 4/10/21; the Guardian sent photos of the bruises to the Director; that Staff #1 told the Director that she had assisted Client #3 with dressing 4/9/21 prior to the home visit and he did not have any marks on his body at that time; and that Client #3 had stated that he did not know how he got the bruises. -There was no documentation of an investigation to determine the cause, age or severity of the bruises of unknown origin. - There was no documentation of efforts to protect Client #3 while an investigation was in process.	V 132		

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V 132	Continued From page 22 Review on 10/4/21 of Client #4's record revealed: -Date of Admission was 6/29/20. -Diagnoses of Schizoaffective Disorder, Depressive Type; Intellectual Developmental Delay - Moderate; Autism Spectrum Disorder. -Progress notes dated 9/22/21 through 9/24/21 revealed no documentation of any behavioral incidents or injuries. -There was no documentation of an investigation to determine the cause, age, or severity of the facial injury or bruising on his stomach. - There was no documentation of efforts to protect Client #3 while an investigation was in process. Observation at approximately 1:40pm on 10/4/21 of Client #4's face and stomach revealed: - A reddened area approximately ¼ inch x ½ inch was present on the temple area on the left side of his face. -A yellowish bruise approximately 1/4-inch x 3 inches was located on the upper left quadrant of his stomach. -7 other pale-yellow bruises ranging in size from approximately ¼ inch to 1 inch across his stomach. -4 scratch-like reddened areas less than approximately ¼ inch long located within the bruised areas on the upper right quadrant of his stomach. Review on 10/4/21 and 10/11/21 of the Incident Response Improvement System (IRIS) revealed: -There were no level 2 or 3 incidents reported by the facility since 4/1/21. - No documentation of notification to the Department of Client #3's injuries of unknown origin that were reported to the Director on 4/19/21. - No documentation of an investigation into the	V 132		

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V 132	Continued From page 23	V 132		

cause of Client #3's bruises of unknow origin.
- There was no documentation of efforts to protect Client #3 while an investigation was in process.
- No documentation of notification to the Department of Client #4's injuries of unknown origin that were present on 10/4/21.
- No documentation of an investigation into the cause of Client #4's facial injury and bruises.
- There was no documentation of efforts to protect Client #4 while an investigation was in process.

Interview on 10/7/21 with Client #4's Peer Support Specialist (PSS) revealed:
-He worked with Client #4 twice a week.
-On Wednesday, 9/22/21, Client #4 did not have any injuries visible.
-On Friday, 9/24/21, " ... His (Client #4's) face was bruised and he had a cut on his face ..."

Interview on 10/7/21 with Client #4's Guardian revealed:
-She and another Department of Social Services (DSS) staff had met Client #4 and Client #4's Peer Support Specialist on 10/1/21.
-Client #4 had a "mark" on his temple.
-Client #4 did not show her the bruises on his stomach because they were in a public place.

Interviews on 10/11/21 and 10/13/21 with the Qualified Professional (QP) revealed:
-The Director was typically the person who informed her of incidents at the facility.
-She was not aware of the bruises that had been on Client # 3's chest and leg on 4/19/21.
-She had not seen the photographs of the bruises on Client #3.
-Typically, facility staff would notify her of injuries of unknown origin, and she would go to the facility

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V 132	Continued From page 24 to investigate further. -She had not been aware of the injury on Client #4's temple or the bruises on his stomach. -If she had known of Client #3 and Client #4's injuries of unknown origin, she would have gone to the facility to investigate further. -Any concerns about clients at the facility should be reported to her so she could investigate. Interviews from 10/4/21 to 10/13/21 with the Director revealed: -Client #3's bruising must have occurred while he was on a home visit from 4/9/21 to 4/19/21. -Client #3 had made the statement that his Guardian "beat" him in the past. -It was difficult to get clear answers from Client #3 about how he sustained injuries. -He did not remember if he had notified the QP of Client #3's injuries. -He did not know how Client #4 got the injury to his temple or the bruises on his stomach. -He had not notified the Department of Client #3's and Client #4's injuries of unknown origin via the IRIS reporting system. -It was his responsibility to complete reports and coordinate evaluations for clients when they had injuries of unknown origin. -He had not completed an investigation into the causes of Clients' #3 and #4's injuries of unknown origin. -He did not have evidence that Clients #3 and #4 had been protected while investigations were conducted. This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type B rule violation and must be corrected within 45 days.	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 133	Continued From page 25	V 133		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall	V 133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAVERNE'S HAVEN RESIDENTIAL SERVICES, LLC	811 OAKWOOD DRIVE EDEN, NC 27288

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 133	Continued From page 26 return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:	V 133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 133	Continued From page 27	V 133		

(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.
The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.
(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:
(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.
(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.
(e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or

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	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 133	Continued From page 28 felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.	V 133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 133	Continued From page 29 (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to request a state and/or nationwide criminal background check for 4 of 6 audited staff (#2, 3, 4 and 5) within 5 days of making the conditional offer of hire. The findings are: Review on 10/6/21 of staff #2's record revealed: -Date of hire was 12/21/18. -He had a Virginia driver's license issued on 10/4/17. -A North Carolina criminal history was requested	V 133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

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V 133	Continued From page 30 on 12/17/18. -No record of a nationwide criminal history background check. Review on 10/6/21 of staff #3's record revealed: -Date of hire was 11/11/17. -He had a South Carolina driver's license issued on 7/18/14. -A North Carolina criminal history was requested on 11/15/17. -No record of a nationwide criminal history background check. Review on 10/6/21 of staff #4's record revealed: -Date of hire was 7/1/21. -A North Carolina criminal history was requested on 10/2/21. Review on 10/6/21 of staff #5's record revealed: -Date of hire was 4/1/21. -He had a Virginia driver's license issued on 3/14/20. -A North Carolina criminal history was requested on 3/31/21. -No record of a nationwide criminal history background check. Interview on 10/11/21 with the Qualified Professional (QP) revealed: -The Director was responsible for completing the background checks -She would check behind the Director. -"If it was late, that one got by me." Interview on 10/12/21 and 10/13/21 with the Director revealed: -He did not know he was supposed to do a national background check for staff who had lived out of state within the past 5 years. -He requested national background checks on	V 133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 133	Continued From page 31 10/12/21 for the staff identified.	V 133		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 291	Continued From page 32	V 291		

facility failed to coordinate care between the facility and qualified professionals who are responsible for treatment/habilitation affecting 1 of 4 clients (#3). The findings are:

Review on 10/12/21 of Client #3's record revealed:
-Admission date was 3/21/18
-Diagnoses of Prater-Willi Syndrome; Intellectual Disability- Moderate; Perseveration/Obsessive Compulsive Disorder (Symptoms related to Prater-Willi Syndrome)
-Progress notes dated 4/19/21 to 5/9/21 revealed:
-Client #3 was on a home visit with his Guardian from 4/9/21 to 4/19/21.
-A 4/19/21 progress note written by Staff #1 revealed that Client #3 returned from his home visit at 12:30 pm and " ...returned with bruises on his leg, chest, and his butt when [Client #3] left from the facility to do his home visit [Client #3] had no marks or bruises on his body ..."
-A 4/19/21 progress note written by the Director revealed that Client #3's Guardian called the Director on an unspecified date and informed him that she had noticed the bruises on 4/10/21; the Guardian sent photos of the bruises to the Director on an unspecified date; that Staff #1 told the Director that she had assisted Client #3 with dressing 4/9/21 prior to the home visit and he did not have any marks on his body at that time; and that Client #3 had stated that he did not know how he got the bruises.
-There was no documentation of an assessment to determine the cause, age or severity of the bruises of unknown origin.

Review on 10/11/21 of photographs provided by Client #3's Guardian revealed:
-The photos were not time-stamped.
-The photos did not show Client #3's face.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

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V 291	Continued From page 33 -A yellowish-brown colored bruise located to the side of a nipple, which was approximately ½ inch in diameter. -A yellowish-brown colored bruise located above the other nipple, which was approximately 1-2 inches in diameter. -A circular, brownish-yellow-colored bruise was located on the outer mid-thigh area and was approximately 2-3 inches in diameter. -A crescent-shaped bruise of similar color was adjacent to the circular bruise and was approximately 5 inches long. -2 reddish areas, that resemble open sores, approximately ¼ - ½ inches in diameter near the bruised area. -4 discolored areas that were pinkish-brown and approximately ¼ - ½ inches in diameter, also near the larger bruise on the thigh. Interview on 10/4/21 with Client #3 revealed: -He was unable to provide any clear information about bruises he sustained in April of 2021. Interview on 10/11/21 with Client #3's Guardian revealed: -Client #3 had greenish-yellow bruises when he came home for a visit in April 2021. -She took photos of the bruises while Client #3 was on the home visit. -She could not remember the exact date that the pictures were taken or when she sent to the Director. -She did not think that Client #3 had been seen by a medical professional to evaluate the bruises. -" ... They're neglecting them ... That was my brother's body with bruises on it ..." Interviews on 10/4/21 & 10/12/21 with Staff #1 revealed: -She never had conversations with Client #3's	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 291	Continued From page 34 Guardian. -When Client #3 returned from a home visit on 4/19/21, he had bruises on his leg and arm. -She reported the bruising to the Director. -Client #3 did not receive medical care for the bruises. -The Director was the facility staff person responsible for scheduling medical appointments. Interviews on 10/11/21 and 10/13/21 with the Qualified Professional (QP) revealed: -She did not have regular contact with Clients' Guardians unless there was an incident to report to them. -She was not aware of the bruises that had been on Client # 3's chest and leg on 4/19/21. -She had not seen the photographs of the bruises on Client #3. -If she had known of Client #3's injuries of unknown origin, she would have gone to the facility to investigate further. Interviews from 10/4/21 to 10/13/21 with the Director revealed: -Client #3 returned to the facility from a 10-day home visit on 4/19/21. -Client #3's Guardian had informed him the day before Client #3 returned on 4/19/21 Client #3 had multiple bruises on his body. -Client #3's Guardian sent him photos of the bruises. -Client #3's bruising "Had to have happened while he was on home visit." -It was difficult to get clear answers from Client #3 about how he sustained injuries. -He did not remember if he had notified the QP of Client #3's injuries. -He had not coordinated medical evaluation of Client #3's bruises because by the time Client #3 returned from the home visit, the bruising was	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 291	Continued From page 35 almost healed. -"Chalk that (not completing an incident report about Client #3's injuries) up to me because I talked to [Client #3's Guardian] and she was fine with it. She kept saying she was fine (with the conversation about the bruises). She thought he (Client #3) could have done it while he was at home. She can't follow up with him like the home (the facility) can." -Client #3 had made the statement his Guardian "beat" him. -He did not report Client #3's accusation against the Guardian to anyone. This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type B rule violation and must be corrected within 45 days.	V 291		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAVERNE'S HAVEN RESIDENTIAL SERVICES, LLC	811 OAKWOOD DRIVE EDEN, NC 27288

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 36	V 366		

preventive measures;
(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and
(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.
(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.
(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 366	Continued From page 37 occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 366	Continued From page 38	V 366		

This Rule is not met as evidenced by:
Based on observation, record reviews and interviews, the facility failed to attend to the health and safety needs of individuals, determine cause of incident, and develop and implement corrective measures affecting 2 of 4 clients (#3 and #4). The findings are:

Refer to Tag V106 for additional background information related to:
- No documentation of incident reporting for level 2 or 3 incidents or investigation of:
--Client #1's AWOL (absent without leave) incident on 4/26/21.
--Client #3's injuries of unknown origin on 4/19/21.
--Client #4's injuries of unknown origin on approximately 9/24/21.
- No evidence of the Qualified Professional (QP) having been notified of Clients #3 and #4's injuries of unknown origin.

Review on 10/12/21 of Client #3's record revealed:
-Admission date was 3/21/18
-Diagnoses of Prater-Willi Syndrome; Intellectual Disability- Moderate; Perseveration/Obsessive Compulsive Disorder (Symptoms related to Prater-Willi Syndrome)
-Progress notes dated 4/19/21 to 5/9/21 revealed:
-Client #3 was on a home visit with his Guardian from 4/9/21 to 4/19/21.
-A 4/19/21 progress note written by Staff #1 revealed that Client #3 returned from his home visit at 12:30 pm and " ...returned with bruises on his leg, chest, and his butt when [Client #3] left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

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V 366	Continued From page 39 from the facility to do his home visit [Client #3] had no marks or bruises on his body ..." -A 4/19/21 progress note written by the Director revealed that Client #3's Guardian called the Director and informed him that she had noticed the bruises on 4/10/21; the Guardian sent photos of the bruises to the Director; that Staff #1 told the Director that she had assisted Client #3 with dressing 4/9/21 prior to the home visit and he did not have any marks on his body at that time; and that Client #3 had stated that he did not know how he got the bruises. -There was no documentation of an assessment or evaluation to determine the cause, age or severity of the bruises of unknown origin. -There was no documentation of an investigation into the cause of bruises. -There was no documentation of development or implementation of corrective measures to prevent further injuries of unknown origin. Review on 10/4/21 of Client #4's record revealed: -Date of Admission was 6/29/20. -Diagnoses of Schizoaffective Disorder, Depressive Type; Intellectual Developmental Delay - Moderate; Autism Spectrum Disorder. -A treatment plan dated 4/26/21 that revealed a history of "aggression and volatility" at previous residential placements that resulted in discharge from placement, physical aggression towards staff and peers, throwing objects, property destruction and running away. -Progress notes dated 9/22/21 through 9/24/21 revealed no documentation of any behavioral incidents or injuries. -There was no documentation of an assessment or evaluation to determine the cause, age, or severity of the facial injury or bruising on his stomach. -There was no documentation of an investigation	V 366		

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V 366	Continued From page 40 into the cause of facial injury or bruising on his stomach. -There was no documentation of development or implementation of corrective measures to prevent further injuries of unknown origin. Observation at approximately 1:40pm on 10/4/21 of Client #4's face and stomach revealed: -A reddened area approximately ¼ inch x ½ inch was present on the temple area on the left side of his face. -A yellowish bruise approximately 1/4-inch x 3 inches was located on the upper left quadrant of his stomach. -7 other pale-yellow bruises ranging in size from approximately ¼ inch to 1 inch across his stomach. -4 scratch-like reddened areas less that approximately ¼ inch long located within the bruised areas on the upper right quadrant of his stomach. Reviews on 10/4/21 and 10/11/21 of the Incident Response Improvement System (IRIS) revealed: -There were no level 2 or 3 incidents reported by the facility since 4/1/21. Review on 10/13/21 of the facility's level 1 incident reports dated 1/2/21 to 10/13/21 revealed: -No incident reports related to Client #3's Guardian having reported that she found bruises on Client #3's body during his 4/9/21 to 4/19/21 home visit. -No incident reports related to Client #4's injury to his face and bruising on his stomach. -There was no documentation of an investigation to determine the cause of Clients' #3 and #4's injuries. -There was no documentation of development or	V 366		

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V 366	Continued From page 41 implementation of corrective measures to address Clients' #3 and #4's injuries of unknown origin. Interviews on 10/11/21 and 10/13/21 with the QP revealed: -The Director was typically the person who informed her of incidents at the facility. -She was not aware of the bruises that had been on Client # 3's chest and leg on 4/19/21. -She had not seen the photographs of the bruises on Client #3. -Typically, facility staff would notify her of injuries of unknown origin, and she would go to the facility to investigate further. -She had not been aware of the injury on Client #4's temple or the bruises on his stomach. -If she had known of Client #3 and Client #4's injuries of unknown origin, she would have gone to the facility to investigate further. -Any concerns about clients at the facility should be reported to her so she could investigate. Interviews from 10/4/21 to 10/13/21 with the Director revealed: -Client #3's bruising must have occurred while he was on a home visit from 4/9/21 to 4/19/21. -Client #3 had made the statement that his Guardian "beat" him in the past. -It was difficult to get clear answers from Client #3 about how he sustained injuries. -He had not completed an incident report to document Client #3's injuries. -He did not remember if he had notified the QP of Client #3's injuries. -He did not know how Client #4 got the injury to his temple or the bruises on his stomach. -It was his responsibility to complete incident reports and coordinate evaluation for clients when they had injuries of unknown origin.	V 366		

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V 366	Continued From page 42 -He had not completed an investigation into the causes of Clients' #3 and #4's injuries. -He did not notify anyone about Client #3's allegation against his guardian. -He had not developed corrective measures to address obtaining assessment of injuries of unknown origin, investigating causes of injuries, and allegations of abuse and/or neglect. This deficiency is cross referenced into 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) for a Type B rule violation and must be corrected within 45 days.	V 366		
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	V 536		

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V 536	Continued From page 43 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; (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.	V 536		

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V 536	Continued From page 44 (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 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.	V 536		

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V 536	Continued From page 45 (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. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide training on alternatives to restrictive interventions prior to 1 of 6 audited staff (#5) providing services. The findings are:	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 46 Review on 10/6/21 of staff #5's record revealed: -Date of hire was 4/1/21. -Training on alternatives to restrictive interventions was completed on 4/29/21. -Staff #5 worked at the facility prior to completing training on 4/29/21. Interview on 10/12/21 with the Qualified Professional (QP) revealed: -The Director sets up the training for alternatives to restrictive interventions. -The facility used the date on the application as the hire date, but the staff didn't start working until another date. -Unsure what the exact situation with Staff #5 was. Interview on 10/12/21 with the Director revealed: -When staff was trained, he threw out the old training records. -He was responsible for ensuring staff were trained in alternatives to restrictive interventions 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 (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	V 537		

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V 537	Continued From page 47 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 (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	V 537		

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V 537	Continued From page 48	V 537		

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 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

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V 537	Continued From page 49	V 537		

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.
(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

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	MHL079-139	A. BUILDING: _____ B. WING _____	C 10/28/2021

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V 537	Continued From page 50 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 review and interviews, the facility failed to provide training in seclusion, physical restraint, and isolation time-out prior to 1 of 6 audited staff (#5) providing services. The findings are: Review on 10/6/21 of staff #5's record revealed: -Date of hire was 4/1/21. -Training on seclusion, physical restraint, and isolation time-out was completed on 4/29/21. -Staff #5 worked at the facility prior to completing training on 4/29/21. Interview on 10/12/21 with the Qualified Professional (QP) revealed: -The Director sets up the training for seclusion, physical restraint, and isolation time-out. -The facility used the date on the application as the hire date, but the staff didn't start working until another date. -Unsure what the exact situation with Staff #5 was. Interview on 10/12/21 with the Director revealed: -When staff was trained, he threw out the old training records.	V 537		

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V 537	Continued From page 51 -He was responsible for ensuring staff were trained in seclusion, physical restraint, and isolation time-out prior to providing services.	V 537		