Appendix 1-B: Plan of Correction Form

Plan of Correction	
Please complete all requested information and mail completed Plan of Correction form to: **Mental Health Licensure and Certification Section** **NC DHSR** **2718 Mail Service Center** **Raleigh, NC 27699-2718**	**In lieu of mailing the form, you may e-mail the completed electronic form to:** Plans.Of.Correction@dhhs.nc.gov

Provider Name:	**Alternatives Residential Care Homes, LLC**	**Phone:**	**704-469-8783**
Provider Contact Person for follow-up:	**Carla Burton Griffin** **Carla Burton Griffin**	**Fax:**	**1 803 630 0376**
		Email:	**cgriffn.alternativesrescare@gmail.com** **alternativesrescarenc@gmail.com**
Address:	**736 Cherryville Road Shelby, NC 28150 Provider # MHL-023-224**		

(X4) ID PREFIXTAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) **Finding**	**Corrective Action Steps**	**Responsible Party**	**Time Line**
V 000 INITIAL COMMENTS An annual and complaint survey was completed on 10/15/21. The complaint was unsubstantiated (intake #NC 177677). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	N/A	N/A	Implementation Date: N/A Projected Completion Date: N/A
V 117 27G .0209 (B) Medication Requirements **10A NCAC 27G .0209 MEDICATION REQUIREMENTS** (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether	**Finding:** A survey conducted by surveyor with NC DHSR revealed that the facility failed to ensure that medications for administration were packaged and labeled as required for 1 of 1 current client as medications were pre-punched in advance for administration. **Immediate steps to address the issue to be corrected:** Effective immediately, medications will cease to be punched in advance and will be placed in cups only at the time of administration and MAR shall be updated a the time of administration in accordance with 10A NCAC 27G	**Administration** **QA/QI Director** **Residential House Manager** **Residential Counselors**	**Implementation Date: Immediately: 10/15/2021** **Projected Completion Date: 12/01/2021** **Medication Administration Training and Re-certifications; Self-Monitoring:** Ongoing

Carla D Griffin QP 10/29/2021

purchasedor obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bagmay be adequate; (3) The packaging label of each prescriptiondrug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expirationdate of the prescribed drug; and (F) the name, address, and phone number of thepharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. This Rule is not met as evidenced by: Based on observation and interviews, the facilityfailed to ensure medications for administration atthe facility were packaged and labeled as required for 1 of 1 current client, (#1). The findings are: Review on 9/1/21 of client #1's record revealed: - Admission date: 4/26/21; - Diagnoses: Oppositional Defiant Disorder (D/O)and Unspecified Depressive Disorder; - Age: 16 Observation on 8/31/21 at 1:00pm of facility'smedication closet revealed: -surveyor observed small plastic cups that weremarked AM and PM; -medication was dispensed in the "PM" cup forClient #1's evening	.0209. Additionally, medications shall remain in packaging and bottles until time of administration; bottles containing medications shall be clearly identified and show the following: client's name; the prescriber's name; the current dispensing date; clear directions for self-administration; the name, strength, quantity, and expiration date of the prescribed drug; and the name, address, and phone number of thepharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner; MAR shall be updated immediately after administration and per 10A NCAC 27G.0209 **Actions to ensure that systemic root causes are identified and addressed:** Administration shall ensure that staff are properly trained in medication administration; staff shall work together with administration to ensure that documentation in the MAR is correct, properly updated and complete. Should any information in the consumer's service record be found out of compliance, an appropriate notation will be made and brought to the attention of the office administration and, as necessary, to the attention of the QP. Office staff will work with office administration and QP, as necessary, to bring record into compliance. Any corrections made to the service record shall be in accordance with RMDM; APSM 45-2. Documentation of said audit shall be kept in a binder for review by Quality and Compliance Specialist **Ongoing Quality Improvement Measures**: Management will ensure that a random monthly audit of at least 1 current and 1 closed consumer records, to include the MAR, shall be conducted to ensure that all required documentation shall be included in the consumer's record, to include an audit of medications, physician's orders, and their documentation in the MAR and consumer's record/chart. An initial training in medication administration and subsequent reviews of required documentation methods shall be conducted with all new and current staff. On a monthly basis the office designee shall receive a log		

medications; -there was no documentation on the "PM" cupwith the current dispense date, name of prescribing provider, or name, strength and quality of the medication with expiration date. Interview on 9/1/21 and 9/3/21 with Client #1revealed: -she gets her medication every day and knew thatshe took medication for anxiety and sleep; -she reported that her medication is already in ina cup when she takes it; -she reported no issues with her medications. Interview on 8/31/21 and 9/1/21 with Director of Operations and Compliance revealed: -she reported that they "pre-punch medications toreduce errors;" -the facility is new and has been open since April23rd, 2021. Interview on 10/15/21 with Director of Operationsand Compliance revealed: -she was unaware of the labeling requirementsthat must be on each cup that contained client medications.	containing the results of any medical record/MAR audits. This log will be in the QA/QI Binder Provider shall ensure that, as a part of the orientation process, that proper medication administration and documentation training is included. Evidence and documentation of this training shall be kept in the staff's personnel record.		
V 118 27G .0209 (C) Medication Requirements **10A NCAC 27G .0209 MEDICATION REQUIREMENTS** (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribedrugs.	**Finding:** Based on record review and interview, the facilityfailed to have physician orders for administered medications, failed to administer medications as ordered by a physician and failed to keep the MAR current affecting 1 of 1 current client, (#1) and 2 of 2 audited former clients, (FC#2, FC#3). Due to failure to maintain physician orders and accurately document medication administration, it could not be determined if clients received	**Administration** **QA/QI Director** **Residential House Manager** **Residential Counselors**	**Implementation Date: 10/15/5/2021** **Projected Completion Date: 12/01/2021** **Medication Administration Training and Re-certifications; Self-Monitoring:** Ongoing

(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be keptcurrent. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MARfile followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview, the facilityfailed to have physician orders for administered medications, failed to administer medications as ordered by a physician and failed to keep the MAR current affecting 1 of 1 current client, (#1) and 2 of 2 audited former clients, (FC#2, FC#3). The findings are: Review on 9/1/21 of Client #1's record revealed: - Admission date: 4/26/21; - Diagnoses: Oppositional Defiant	medications as ordered. **Immediate steps to address the issue to be corrected:** Effective immediately, administration shall communicate with staff to ensure that physician's orders are in consumers' records **as opposed to relying on after-visit summaries printed at the doctors' office that contain the medications and dosages**; consumer's medical records shall contain physicians' orders and not rely on the after-visit clinical summaries which list the medications and dosages in accordance with 10A NCAC 27G .0209. Additionally, medications shall not be pre-punched, but remain in packaging and bottles with clearly identified client's name; the prescriber's name; the current dispensing date; clear directions for self-administration; the name, strength, quantity, and expirationdate of the prescribed drug; and the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner per 10A NCAC 27G.0209; all administered medications shall be recorded immediately in the MAR **Actions to ensure that systemic root causes are identified and addressed:** Administration shall ensure that physician's orders are in consumers' records **as opposed to relying on after-visit summaries printed at the doctors' office that contain the medications and dosages**; administration will ensure that staff are properly trained in medication administration; staff shall work together with administration to ensure that the documentation in the MAR is correct, properly updated and complete. Should any information in the consumer's service record be found out of compliance, an appropriate notation will be made and brought to the attention of the office administration and, as necessary, to the attention of the QP. Office staff will work with office administration and QP, as necessary, to bring record into compliance. Any corrections made to the service record shall be in accordance with RMDM; APSM 45-2. Documentation of		

Disorder (D/O)and Unspecified Depressive Disorder; - Age: 16 Review on 08/31/21 of June 2021 to August 2021MARs and physician orders for Client #1 revealed: -Hydroxyzine 25 milligrams (mg), as needed (PRN) daytime (for anxiety), and 50mg, 1 time per day at bedtime; -Clonidine 0.1 mg at bedtime (for anxiety) starting8/12/21; -Melatonin 10mg, 1 time per day, PRN (for sleep); -Omeprazole 20mg, take one tablet beforebreakfast (for heartburn/indigestion); -Sertraline 75mg, take 1 time per day (for depression/anxiety) starting 7/15/21; -Zyrtec 10mg, take 1 time per day, (for allergies); -Metronidazole 500mg, 1 tablet, twice a day,(BID), (antibiotics), starting 8/23/21; -Ondansetron HCL 4mg, 1 tablet every 8 hoursPRN (for nausea); -blanks on MAR for Metronidazole dosages for 8/29/21, and 8/30/21; -blanks on MAR for Clonidine dosages for 8/27/21-8/30/21. -the facility had no physician orders for Client #1; -there was a medication review signed by a physician regarding Client #1's Clonidine in the file, however, the dosage was not listed. Review on 9/1/21 of FC #2's record revealed: -Admission date: 5/20/21; -Diagnoses: Major Depressive Disorder (D/O),Unspecified Anxiety D/O, and Post Traumatic Stress	said audit shall be kept in a binder for review by Quality and Compliance Specialist **Ongoing Quality Improvement Measures**: Management will ensure that a random monthly audit of at least 1 current and 1 closed consumer record, to include the MAR, shall be conducted to ensure that all required documentation shall be included in the consumer's record; audit shall include an audit of medications, physicians' orders, and their documentation in the MAR. An initial training in medication administration and subsequent reviews of required documentation methods shall be conducted with all new and current staff. On a monthly basis the office designee shall receive a log containing the results of any medical record/MAR audits. Provider shall ensure that, as a part of the orientation process, that proper documentation training is included. Evidence and documentation of this training shall be kept in the staff's personnel record.		

Disorder; -Discharge date: 7/19/21; -Age:17 Review on 8/31/21 of May 2021 to July 2021 MARS and physician orders for FC#2 revealed: -Clonidine 0.2mg, take 1 at bedtime (QHS) (for anxiety), ordered 5/17/21 and changed to 0.3 mgon 6/6/21; and then to 0.4mg on 7/7/21 with no discontinue order in file; -Lexapro 10mg, take 1 tablet at bed time (for depression/anxiety), ordered 5/17/21, stop date of6/6/21 with no discontinue order; -Latuda 80 mg, 1 time per day (mood regulation)ordered 5/17/21; -Latuda 60mg, take 1 time per day, started 7/7/21 and stopped 7/15/21, with no discontinue order infile; -Latuda 40mg 1 time per day with dinner, started 7/15/21 with no discontinue order in file; -Melatonin 10mg, 1 time a day (to help with sleep), ordered 6/4/21 with no change order in file; -Zofran 4mg, 1x a day, take with Latuda (fornausea), ordered 7/2/21; -Nexium 40mg, 1 time a day before meal (for reflux, indigestion) started 5/27/21, with no orderin file; -Lamictal 25mg tabs, take 1 tab QHS (for mood regulation) starting 6/6/21, changed to 2 tabs, (50mg) QHS on 7/7/21 and stopping 7/15/21 withno order in file. Interview on 9/3/21 with FC#2's Guardian revealed: -she did not have concerns about FC# 2 getting her medications; -FC#2 was about to be 18 years old and recognized when her medications weren't working for her.			

Review on 9/1/21 of FC#3's record revealed: -Admission date: 4/23/21; -Diagnoses: Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, and Disruptive Mood Dysregulation Disorder; -Discharge date: 8/29/21; -Age: 16 Review on 8/31/21 of MARs dated June 2021 toAugust 2021 and physician orders for FC#3 revealed: -Vyvanse 50mg, take 1 time per day, every morning (QAM) (for attention deficit) and original order on 5/10/21, Vyvanse 30mg 1 time QAM (forattention deficit); -Multi-vitamin 2X a day per package instructionswith original order on 5/10/21, take 1 tablet everyday (QD); -Trazadone 50mg, take one time per day at bedtime (QHS) (for sleep) which is different dosage than originally ordered on 5/10/21, Trazadone 50mg, 1 tablet BID; -Clindamycin Phosphate Topical, started 6/7/21(for acne); with no prescription in file; Interview on 9/3/21 with FC#3's Guardianrevealed: -no concerns with FC#3's medications whilestaying at the facility. Interview on 8/31/21, and 9/1/21 with Director of Operations and Compliance revealed: -she kept documentation of physician visits inclients' file; -she did not have physician orders for medications and thought appointment notes would suffice; -she would obtain prescriptions moving forward to be in compliance with State			

rules. Due to failure to maintain physician orders and accurately document medication administration, it could not be determined if clients received medications as ordered.			
V 536 27E .0107 Client Rights - Training on Alt to Rest.Interventions **10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS** (a) Facilities shall implement policies and practices that emphasize the use of alternativesto 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 ofbehavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be	**Finding:** Based on record review and interview, the facility failed to ensure that 1 of 3 audited staff, (#3) had current training in use of alternatives to restrictive intervention. **Immediate steps to address the issue to be corrected:** Effective immediately, administration shall ensure that, prior to providing services, that all staff are properly trained by appropriately certified trainers and demonstrate competence in the area of Clients Rights on Alternatives to Restrictive Interventions in accordance with 10A NCAC 27E .0107. Documentation of said training shall be in the personnel record of staff. **Actions to ensure that systemic root causes are identified and addressed:** Administration shall ensure that, prior to service provision, that each staff is properly trained and demonstrates competence in the skills necessary for creating an environment in which the likelihood of imminent danger, abuse, or personal injury to a person with disabilities or others or property damage can be prevented; administration will ensure that staff will work along with administration to ensure that the employment screening and hiring process includes measures to secure trainings required prior to service provision are secured; documentation of such training is shall be placed in the employment record of staff. **Ongoing Quality Improvement Measures**: Management will ensure that a random, monthly audit of at least 1 current and 1 former staff record, shall be conducted to ensure that all required documentation shall be included in the employment record; audit shall include an audit of job qualifications and training requirements for service	**Administration** **QA/QI Director** **Residential House Manager** **Residential Counselors**	**Implementation Date: 10/15/5/2021** **Projected Completion Date: 12/01/2021** **Clients Rights Training on Alternatives to Restrictive Interventions; Re-certifications; Self-Monitoring:** Ongoing

completedby each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved bythe Division of MH/DD/SAS pursuant to Paragraph of this Rule. (g) Staff shall demonstrate competence in thefollowing core areas: (1) knowledge and understanding of thepeople being served; (2) recognizing and interpreting humanbehavior; (3) recognizing the effect of internal andexternal stressors that may affect people withdisabilities; (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 makingdecisions about their life; (7) skills in assessing individual risk forescalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providingmeans 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 forat least three years. (1) Documentation shall include: (A) who participated in the	provision. Should any information in the employment record be found out of compliance, an appropriate notation will be made and brought to the attention of the office administration and, as necessary, to the attention of the QP. Office staff will work with office administration and QP, as necessary, to bring record into compliance. Any corrections made to the service record shall be in accordance with RMDM; APSM 45-2. Documentation of said audit shall be kept in a binder for review by Quality and Compliance Specialist On a monthly basis the office designee shall receive a log containing the results of any medical record/MAR audits. Provider shall ensure that, as a part of the orientation process, that proper documentation training is included. Evidence and documentation of this training shall be kept in the staff's personnel record.		

training and theoutcomes (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 TrainingRequirements: (1) Trainers shall demonstrate competenceby scoring 100% on testing in a training programaimed at preventing, reducing and eliminating theneed for restrictive interventions. (2) Trainers shall demonstrate competenceby scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learningobjectives, measurable testing (written and by observation of behavior) on those objectives andmeasurable methods to determine passing or failing the course. (4) The content of the instructor training theservice provider plans to employ shall be approved by the Division of MH/DD/SAS pursuantto Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programsshall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experienceteaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.			

(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating theneed for restrictive interventions at least once annually. (8) Trainers shall complete a refresherinstructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructortraining for at least three years. (1) Documentation shall include: (A) who participated in the training and theoutcomes (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 preparationrequirements as a trainer. (2) Coaches shall teach at least three timesthe course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching ortrain-the-trainer instruction. (l) Documentation shall be the same preparationas for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 of 3 audited staff, (#3) had current training in use of alternatives to restrictive intervention. The findings are: Review on 9/2/21 of Staff #3 personnel recordrevealed: Hire date: 8/18/21; No documentation of training on alternatives torestrictive intervention			

documented in file. Interview on 9/1/21 of Staff #3 revealed: -she was hired on 8/18/21; -there had been no restraints at the facility; -she reported that the facility had 30 days tocomplete the training. -she was always on shift with another staff thatwas trained. Interview on 9/8/21 with Director of Operationsand Compliance revealed: -she thought that the facility had 30 days to getthis training completed; -she will have employees complete this trainingprior to working moving forward.			

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 alternativesto these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.
(b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-outand 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 eliminatingthe need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation ofbehavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completedby each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved bythe Division of MH/DD/SAS pursuant to Paragraph of this Rule. (g) Acceptable training programs shall include,but are not limited to, presentation of: (1) refresher information on alternatives tothe use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self andothers); (3) emphasis on safety and respect for therights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementationof restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safeuse of restraint throughout the duration of the restrictive intervention;			

(6) prohibited procedures; (7) debriefing strategies, including theirimportance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training forat least three years. (1) Documentation shall include: (A) who participated in the training and theoutcomes (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 TrainingRequirements: (1) Trainers shall demonstrate competenceby scoring 100% on testing in a training programaimed at preventing, reducing and eliminating theneed for restrictive interventions. (2) Trainers shall demonstrate competenceby scoring 100% on testing in a training programteaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competenceby scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learningobjectives, measurable testing (written and by observation of behavior) on those objectives andmeasurable methods to determine passing or failing the course. (5) The content of the instructor training theservice provider plans to employ shall be approved by the Division of MH/DD/SAS pursuantto			

Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programsshall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of thecourse; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the useof seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of thisRule. (8) Trainers shall be currently trained inCPR. (9) Trainers shall have coached experiencein teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on theuse of restrictive interventions at least once annually. (11) Trainers shall complete a refresherinstructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructortraining 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 preparationrequirements as a trainer.			

(2) Coaches shall teach at least threetimes, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching ortrain-the-trainer instruction. (m) Documentation shall be the samepreparation as for trainers This Rule is not met as evidenced by: Based on record review and interview, the facilityfailed to ensure that 1 of 3 audited staff, (#3) hadcurrent training in use of seclusion, physical restraints, and isolation time out. The findings are: Review on 9/2/21 of Staff #3 personnel recordrevealed: Hire date: 8/18/21; No documentation of training in use of seclusion,physical restraint, or isolation time out documented in file. Interview on 9/1/21 of Staff #3 revealed: -she was hired on 8/18/21; -there had been no restraints at the facility; -she reported that the facility had 30 days to complete the training. Interview on 9/8/21 with Director of Operationsand Compliance revealed: -she thought that the facility had 30 days to getthis training completed; -she will have employees complete this training prior to working moving forward.			
			Implementation Date: 10/15/5/2021
V 537 27E .0108 Client Rights - Training in Sec Rest &ITO	**Finding:** Based on record review and interview, the facility failed to ensure that 1 of 3 audited staff, (#3) had	**Administration**	**Projected Completion Date: 12/01/2021**

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 alternativesto these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (h) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-outand shall not use these interventions until the training is completed and competence is demonstrated. (i) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminatingthe need for restrictive interventions. (j) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation ofbehavior) on those objectives and measurable methods to determine passing or failing the course. (k) Formal refresher training must be completedby each service provider periodically (minimum annually). (l) Content of the training that the service provider plans to employ	current training in use of alternatives to restrictive intervention. **Immediate steps to address the issue to be corrected:** Effective immediately, administration shall ensure that, prior to providing services, that all staff are properly trained by appropriately certified trainers and demonstrate competence in the area of Seclusion, Physical Restraint and Isolation Time Out in accordance with 10A NCAC 27E .0108. Documentation of said training shall be in the personnel record of staff. **Actions to ensure that systemic root causes are identified and addressed:** Administration shall ensure that, prior to service provision, that each staff is properly trained and demonstrates competence in the skills necessary for creating an environment in which the likelihood of imminent danger, abuse, or personal injury to a person with disabilities or others or property damage can be prevented; administration shall ensure that staff who employ and terminate these procedures are trained by certified trainers; administration will ensure that staff will work along with administration to ensure that the employment screening and hiring process includes measures to secure trainings required prior to service provision are secured; documentation of such training is shall be placed in the employment record of staff. **Ongoing Quality Improvement Measures**: Management will ensure that a random, monthly audit of at least 1 current and 1 former staff record, shall be conducted to ensure that all required documentation shall be included in the employment record; audit shall include an audit of job qualifications and training requirements for service provision. Should any information in the employment record be found out of compliance, an appropriate notation will be made and brought to the attention of the office administration and, as necessary, to the attention of the QP. Office staff will work with office administration and QP, as necessary, to bring record into compliance. Any corrections made to the service record shall be in accordance with	**QA/QI Director** **Residential House Manager** **Residential Counselors**	**Seclusion, Physical Restraint, and Isolation Time Out; Re-certifications; Self-Monitoring:** Ongoing

must be approved bythe Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (m) Acceptable training programs shall include,but are not limited to, presentation of: (4) refresher information on alternatives tothe use of restrictive interventions; (5) guidelines on when to intervene (understanding imminent danger to self andothers); (9) emphasis on safety and respect for therights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (10) strategies for the safe implementationof restrictive interventions; (11) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safeuse of restraint throughout the duration of the restrictive intervention; (12) prohibited procedures; (13) debriefing strategies, including theirimportance and purpose; and (14) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training forat least three years. (2) Documentation shall include: (A) who participated in the training and theoutcomes (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	RMDM; APSM 45-2. Documentation of said audit shall be kept in a binder for review by Quality and Compliance Specialist On a monthly basis the office designee shall receive a log containing the results of any medical record/MAR audits. Provider shall ensure that, as a part of the orientation process, that proper documentation training is included. Evidence and documentation of this training shall be kept in the staff's personnel record.		

and TrainingRequirements: Trainers shall demonstrate competenceby scoring 100% on (3) testing in a training program aimed at preventing, reducing and eliminating theneed for restrictive interventions. (4) Trainers shall demonstrate competenceby scoring 100% on testing in a training programteaching the use of seclusion, physical restraint and isolation time-out. (6) Trainers shall demonstrate competenceby scoring a passing grade on testing in an instructor training program. (7) The training shall be competency-based, include measurable learningobjectives, measurable testing (written and by observation of behavior) on those objectives andmeasurable methods to determine passing or failing the course. (8) The content of the instructor training theservice provider plans to employ shall be approved by the Division of MH/DD/SAS pursuantto Subparagraph (j)(6) of this Rule. (9) Acceptable instructor training programsshall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of thecourse; (C) evaluation of trainee performance; and (D) documentation procedures. (12) Trainers shall be retrained at least annually and demonstrate competence in the useof seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of thisRule. (13) Trainers shall be currently			

trained inCPR. (14) Trainers shall have coached experiencein teaching the use of restrictive interventions at least two times with a positive review by the coach. (15)			