STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-669	A. BUILDING: _____ B. WING _____	R 01/11/2022

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 1/11/22. Intake #NC00183243 was unsubstantiated. Intake #NC00182963 was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. The survey sample consisted of audits of 4 current clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their	V 108		

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V 108	Continued From page 1 equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain a file that included trainings in first aid/cardiopulmonary resuscitation (CPR) for 2 of 3 audited staff (#2 & #3). The findings are: Review on 12/2/21 of Staff #2's personnel record revealed: -Various dates of hire and re-hire -No training in CPR/First Aid in the record Review on 12/2/21 of Staff #3's personnel record revealed: -Hire date of 1/16/17 -No training in CPR/First Aid present in the record Interview on 11/30/21 Staff #2 reported: -He had been working at the facility, on and off, for a long time -He had all of his trainings and they are updated annually -All of his trainings were at the main office Interview on 12/2/21 the Chief Operating Officer (COO) reported: -All staff were current in CPR/First Aid -She would get the updated certificates -Staff #2 had been working with the agency for	V 108		

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V 108	Continued From page 2 awhile but she couldn't "pinpoint" an exact rehire date but would get it No training was received by the exit of the survey, 1/11/22.	V 108		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to develop and implement goals or strategies to address needs for 1 of 4 audited clients (#2) and failed to ensure a current treatment plan affecting 1 of 4 audited clients (#3). The findings are: A. Review on 11/30/21 of client #2's record revealed: -Admitted 5/5/21 -Diagnoses: Schizoaffective Disorder, Bipolar type, Anxiety Disorder, Unspecified and Dyslipidemia Review on 12/9/21-12/10/21 of client #2's treatment plan dated 4/27/21 revealed: -"How Best to Support....Add what's working/what's not working: Elopement from the facility" - The treatment plan did not include any strategies for client #2's elopement Review on 11/30/21-12/10/21 of the facility's level II incident reports revealed: -No incident reports for elopements during the time period of 6/01/21-11/30/21 Facility's Elopement policies were not received prior to the exit of the survey 1/11/22. Interview on 12/2/21 the Chief Operating Officer (COO) reported: -She would fax the elopement policies to DHSR surveyors Interview on 11/30/21 Client #2 reported: -Haven't walked way from the group home since	V 112		

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V 112	Continued From page 4	V 112		

June or July of 2021
-Walked to a cafe and a pizzeria place, walked inside and "told a guy to call the cops"
-Was taken to local psychiatric hospital

Interview on 11/30/21 Staff #2 reported:
-Client #2 eloped a couple weeks ago, the beginning of November 2021
-He went to the local psychiatric hospital on 11/14/21-11/18/21 after the elopement
- He also eloped on 11/28/21 and he was taken to the local hospital and returned the same night
-Client #2 had a history of elopements

Interview on 12/14/21 the Qualified Professional (QP) reported:
-Elopement should have been in client #2 treatment plan

B. Review on 11/30/21 of Client #3's record revealed:
-Admitted 7/30/20
-Diagnoses: Schizoaffective Disorder-bipolar type, Intellectual and Developmental Disability-mild, Diabetes Type 2 and Asthma
-Treatment Plan dated 4/18/20 and signed 7/21/20

Interview on 12/2/21 the Chief Operating Officer (COO) reported:
-The QP was responsible for completing the treatment plans
-Treatment plans were all current
-Current treatment plans should have been in all the clients' records
-She would get an updated copy for client #3 from the QP to put in the record

Interview on 12/3/21 the QP reported:
-She was responsible for completing treatment

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V 112	Continued From page 5 plans -She updated treatment plans every 3 months -The facility had a chart auditor who checked biweekly or monthly that plans were in the charts -She would check on the most recent plan for client #3 - She updated every 3 months for the authorization of the plan -Protocol for elopement is to call 911 and ask for the Crisis Intervention Team (CIT) officer	V 112		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to perform six-month reviews of the drug regimens for 4 of 4 audited clients (#1, #2, #3 & #4) receiving psychotropic medications. The findings are:	V 121		

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V 121	Continued From page 6 Review on 11/30/21 Client #2's record revealed: -Admitted 5/5/21 -Diagnoses Schizoaffective Disorder, Bipolar Type, Anxiety Disorder, Unspecified and Dyslipidemia -No 6 month drug regimen review performed by the pharmacist or physician. Review on 11/30/21 Client #3's record revealed: -Admitted 7/30/20 -Diagnoses: Schizoaffective Disorder-bipolar type, Intellectual and Developmental Disability-mild, Diabetes Type 2 and Asthma -No 6 month drug regimen review performed by the pharmacist or physician. Review on 11/30/21 Client #4's record revealed: -Admitted 5/18/21 -Diagnoses Disruptive Mood Dysregulation Disorder, Intellectual Developmental Disorder and Mild Schizoaffective Disorder, Bipolar type -No 6 month drug regimen review performed by the pharmacist or physician. Review on 12/14/21 Client #1's record revealed: -Admitted 10/23/20 -Diagnosis: Schizoaffective Disorder bipolar type -No 6 month drug regimen review performed by the pharmacist or physician. Interview on 12/3/21 the Qualified Professional (QP) reported: -The facility's Licensed Practical Nurse (LPN) completed the psychotropic reviews. -She believed the LPN did the reviews every 6 months. -She would get the last 2 reviews and fax them. No Psychotropic reviews were received prior to end of survey on 1/11/22	V 121		

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V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL 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 interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was completed before hire affecting 2 of 3 audited staff (#1, #2). The findings are: Review on 12/2/21 of Staff #1's record revealed: -Date of hire 11/7/17 -No HCPR in record Review on 12/2/21 of Staff #2's record revealed: -Various dates of hire and re-hire -Multiple HCPR checks in the record but unable to determine the correct one with no actual hire date. Interview on 11/30/21 Staff #2 reported: -He had been working at the facility, on and off, for a long time -He had all of his trainings and they are updated annually -All of his trainings were at the main office	V 131		

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V 131	Continued From page 8 Interview on 12/2/21 the Chief Operating Officer (COO) reported: -Staff #2 had been working with the agency for awhile but she couldn't "pinpoint" an exact rehire date but would get it. -All staff receive an HCPR check when they are hired or re-hired as well as throughout their employment. -Had various HCPR checks completed for staff #2 but would get the one around his hire date when she was able to locate his hire date. No re-hire date for staff #2 was given by the end of this survey, 1/11/22.	V 131		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum	V 290		

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V 290	Continued From page 9 of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a client's treatment or habilitation plan documented the client was capable of remaining in the community without supervision for specified periods of time affecting 1 of 4 audited clients (#4). The findings are: Review on 12/14/21 of Client #4's record revealed: - Admitted 5/18/21 - Diagnosis: Mood Dysregulation Disorder, Intellectual Developmental Disorder, Mild	V 290		

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V 290	Continued From page 10 Schizoaffective Disorder, and Bipolar type Review on 12/14/21 of Client #4's treatment plan dated 3/15/21 revealed: -Goal 2 Client #4 "will decrease overall intensity and frequency of angry feelings and increase ability to recognize the appropriately express angry feelings as they occur, learn social and communication skills, demonstrate respect for others and their feelings and not elope fro the facility" -"Unsupervised time: No unsupervised time in the community" -"Supervised time: Will be supervised by a staff member while in the facility and out in the community" Review on 12/16/21 of Client #4's updated treatment plan 5/27/21 revealed: -"The guardian has approved for Client #4 to have 6 hours of unsupervised time in the community for him to go to work" Review on 1/6/22 of Client #4's Facility's Community Supervision Checklist dated 12/9/21 revealed: - "Unsupervised time: 6 hours to go to work" - "Supervision Time: the remainder of the day" Interview on 12/14/21 Client #4 reported: -Employed at a local department store as a cashier/stocker -Was on the schedule Monday-Friday to work 4 or 5 hours a day -Had caught the bus to and from work -Did not have a peer support specialist (PSS) worker on the date of interview -Walked to the bus stop on work days -Was a 10 minute walk to and from the bus stop	V 290		

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V 290	Continued From page 11 Interview on 12/17/21 Client #4's Guardian reported: -Did approve 6 hours of unsupervised time -Did not know the specifics about the walk to and from the bus stop -Did not know the times that he would walk to and from the bus stop -"Hadn't crossed my mind that he would become aggressive in public" -Only had outburst and behaviors in the home not any reported in the community Interview on 12/20/21 Staff #2 reported: -Client #4 walked 10-15 to and from the bus -Client #4 had aggressive behaviors towards staff and clients Interview on 12/03/21 Former Staff #5/PSS worker reported: -Unaware if client #4 had unsupervised time -Aware of aggressive behaviors toward staff and other clients Interview on 12/3/21 & 12/16/21 the Qualified Professional (QP) reported: -Client #4 had 4-6 hours of unsupervised time approved by guardian to go to work -Client #4 had worked at a local department store, previously with a PSS worker -His PSS worker no longer worked with the company since approximately beginning of November -Client #4 called the manager of the local department store to get the hours he had to work for the week -Talked with Guardian to discuss unsupervised time, with client #4 behaviors he would leave the home unsupervised -Discussed client #4 going to work to avoid	V 290		

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V 290	Continued From page 12 behaviors	V 290		
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 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	V 366		

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V 366	Continued From page 13	V 366		

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 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

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ANN'S HAVEN OF REST	1016 EAST MILLBROOK ROAD RALEIGH, NC 27609

(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 14 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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop and implement written policies governing their response to incidents as required. The findings are: Review on 12/3/21 of the facility's incident reporting policy revealed: -"The Executive Director ensures that Level I, II or III incidents are responded to by assigning staff directly involved with the resident and the OP to.....c. Develop and implement corrective measures; d. Develop and implement measures to prevent similar incidents, which will be	V 366		

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V 366	Continued From page 15	V 366		

monitored by the Human Rights and QA/QI Committees; and e. Be responsible for implementation of the corrections and preventative measures"

A. Review on 11/30/21 Client #2's record revealed:
-Admitted: 5/5/21
-Diagnoses: Schizoaffective Disorder, Bipolar type, Anxiety Disorder, Unspecified and Dyslipidemia

Review on 12/2/21 of the facility's incident report for Client #2 revealed:
- 6/5/21 1:30am Police brought client home, staff unaware client was out of the house, client was knocking on the neighbors doors asking for cigarettes
-6/30/21 4:45pm taken to local hospital and involuntary committed
-11/14/21 4:46pm 911 was called client walked away from the facility
-11/28/21 4:00pm called 911 and request Crisis Intervention Team (CIT). Transported to the local hospital.
-Nothing in record to show implementation of measures to prevent similar incidents

B. Review on 11/30/21 Client #3's record revealed:
-Admitted 7/30/20
-Diagnoses: Schizoaffective Disorder-bipolar type, Intellectual and Developmental Disability-mild, Diabetes Type 2 and Asthma

Review on 12/3/21 of the facility's incident report for client #3 revealed:
-11/1/21 10:00am Local Police were called because client #3 was threatening to kill staff
-Client #3 was transported to a crisis and

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V 366	Continued From page 16 behavioral facility -Nothing in record to show implementation of measures to prevent similar incidents C. Review on 12/2/21 Client #4's record revealed: -Admitted: 5/18/21 - Diagnoses: Disruptive Mood Dysregulation Disorder, Intellectual Developmental Disorder, Mild and Schizoaffective Disorder, Bipolar type Review on 11/30/21 of the facility's incident report for client #4 revealed: -11/08/21 5:38pm client eloped, police were called, client was found at the local emergency department -11/24/21 7:00pm client walked away from the group home, was found by the police and taken to the local psychiatric hospital -Nothing in record to show implementation of measures to prevent similar incidents Interview on 12/2/21 & 12/3/21 the Qualified Professional (QP) reported: -It wasn't a problem for client #3 so they didn't put anything in place to prevent it from happening again -She would have a team meeting to address these issues so that this didn't happen again for client #2, #3 and #4 -She was notified by staff if a client was being aggressive or having behaviors	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during	V 367		

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the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and

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V 367	Continued From page 18 (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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V 367	Continued From page 19 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report Level II incidents within 72 hours affecting 2 of 4 audited clients (#2, #3). The findings are: Review on 11/30/21 & 1/7/22 of the Incident Response Improvement System (IRIS) revealed: -No reports for this facility or for client #2 & #3 Review on 12/3/21 of the facility's incident reporting policy revealed: -"The Executive Director assures that Level II or Level III incidents are reported to the local area authority/LME (Local Management Entity) within 72 hours of the incident". Review on 11/30/21 Client #2's record revealed: -Admitted: 5/5/21 -Diagnoses: Schizoaffective Disorder, Bipolar type, Anxiety Disorder, Unspecified and Dyslipidemia Review on 12/2/21 of the facility's incident report for client #2 revealed: - 6/5/21 1:30am Police brought client home, staff unaware client was out of the house, client was knocking on the neighbors doors asking for cigarettes -6/30/21 4:45pm taken to local hospital and involuntary committed -11/14/21 4:46pm 911 was called client walked away from the facility -11/28/21 4:00pm called 911 and request Crisis Intervention Unit (CIT). Transported to the local hospital	V 367		

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V 367	Continued From page 20 Review on 11/30/21 Client #3's record revealed: -Admitted 7/30/20 -Diagnoses: Schizoaffective Disorder-bipolar type, Intellectual and Developmental Disability-mild, Diabetes Type 2 and Asthma Review on 12/22/21 of the local police call service log revealed: -11/1/21 12:08pm Miscellaneous/Mental Commitment for client #3 Review on 12/22/21 of the Police report for client #3 revealed: -"This report is in reference to a mental commitment from a mental health living facility located at the address above. The respondent made threats to the caretaking staff and for police to shoot him. He was transported to CAS without incident". Interview on 12/3/21 & 1/4/22 the Qualified Professional (QP) reported: -IRIS had not been completed for client #2 or #3 -Didn't do IRIS for police coming to the facility or hospital visits -Was told they didn't have to do IRIS and would find the email that said it -Client #2 was currently at a psychiatric hospital -He eloped on 12/29/21 and walked to the shopping center close to the facility -He came back to the facility with the police and stated that he wanted to go to the hospital -Local police transported him to the hospital -This recent incident was not completed in IRIS	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int.	V 536		

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V 536	Continued From page 21 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and	V 536		

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external stressors that may affect people with disabilities;
(4) strategies for building positive relationships with persons with disabilities;
(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;
(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;
(7) skills in assessing individual risk for escalating behavior;
(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and
(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).
(h) Service providers shall maintain documentation of initial and refresher training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where they attended; and
(C) instructor's name;
(2) The Division of MH/DD/SAS may review/request this documentation at any time.
(i) Instructor Qualifications and Training Requirements:
(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(3) The training shall be

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V 536	Continued From page 23	V 536		

competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may request and review this documentation any time.
(k) Qualifications of Coaches:

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V 536	Continued From page 24 (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 interview the facility failed to ensure formal refresher training on Alternatives to Restrictive Interventions was completed for 1 of 3 audited staff (#2) at least annually. The findings are: Review on 12/2/21 of Staff #2's personnel record revealed: -Various dates of hire and re-hire -NCI+ -Prevention training expired 7/24/21 -No updated training Interview on 12/2/21 the Chief Operating Officer (COO) reported: -All staff were current in NCI -She would get the updated certificates -Staff #2 had been working with the agency for awhile but she couldn't "pinpoint" an exact rehire date but would get it Interview on 1/5/22 & 1/6/22 the Qualified Professional (QP) reported:	V 536		

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V 536	Continued From page 25 -Nonviolent Crisis Intervention (NCI) was the training the facility used -"The state requirements required the staff to have NCI" Review on 1/7/22 of the facility's restraint policy revealed: -"Staff are trained on NCI.....formal refresher training must be completed by each service provider periodically (minimum annually)." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 536		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on interview and observation, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 11/30/21 at 12:38pm revealed the following: Bathroom between Client #2 & #3's room: -Floor buckling and lifting up -Cabinet door under the sink was loose and did not completely close	V 736		

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V 736	Continued From page 26 2nd floor Bathroom: -Light in middle of the ceiling did not have a working lightbulb Client #4's room: -Light fixture plate/cover by the window was missing Client #5's room: -1 lightbulb out in the ceiling light fixture Basement: -Several steps going down into the basement were wobbly Interview on 11/30/21 Staff #2 reported: -Maintenance was called around the end of October and again the first of November 2021 to make repairs -Staff #2 would replace all the lightbulbs that were out This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		