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MELODY HOUSE#1, LLC	3116 CEDARWOOD DRIVE DURHAM, NC 27707

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on August 24, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 2 current clients and 1 former client.	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 equivalence for relieving airway obstruction.	V 108		

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V 108	Continued From page 1 (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 reviews and interviews, the facility failed to ensure two of four audited staff (#1 and #2) had training in Cardiopulmonary Resuscitation (CPR); one of four audited staff (#2) had training in First Aid (FA) and three of four audited staff (#1, #2 and Program Coordinator) had training to meet the mental health and developmental disability needs of the clients as specified in the treatment/habilitation plan. The findings are: a. Review on 8/22/22 of client #1's record revealed: -Admission date of 2/14/19. -Diagnoses of Schizoaffective Disorder, Hypersalivation, Tachycardia, Nephrogenic Diabetes Insipidus, Osteopenia, Overweight, Vitamin D deficiency, Hyperlipidemia and Tinea Pedis. b. Review on 8/22/22 of client #2's record revealed: -Admission date of 8/11/22. -Diagnoses of Schizoaffective Disorder-Bipolar Type, Obesity, Cocaine Use Disorder, Cannabis Use Disorder and Type II Diabetes, History of Seizure Disorder and Vitamin D Deficiency.	V 108		

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V 108	Continued From page 2	V 108		

c. Review on 8/22/22 of client #3's record revealed:
-Admission date of 7/29/19.
-Diagnoses of Schizophrenia, Hypertension, Hyperlipidemia, Morbid Obesity, Vitamin D Deficiency and Normocytic Anemia.

d. Review on 8/22/22 of client #4's record revealed:
-Admission date of 12/27/19.
-Diagnoses of Schizoaffective Disorder-Bipolar type, Hypertension, Coronary Artery Disease, Type II Diabetes, Nonrheumatic Aortic Valve Insufficiency and History of Ascending Aortic Aneurysm.

e. Review on 8/22/22 of FC #5's record revealed:
-Admission date of 4/16/14.
-Diagnoses of Schizophrenia-Paranoid Type, Osteopenia, Chronic Obstructive Pulmonary Disease and Tobacco Use Disorder.
-Discharge date of 8/16/22.

Review on 8/23/22 of the facility's personnel records revealed the following:

Staff #1:
-No date of hire.
-Hired as a Habilitation Technician.
-CPR training was completed on 2/2/21 online.
-No documentation of training to meet the mental health and developmental disability needs of the clients as specified in the treatment/habilitation plan.

Staff #2:
-No date of hire.
-Hired as a Habilitation Technician.
-No documentation of CPR and FA training.
-No documentation of training to meet the mental

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V 108	Continued From page 3 health and developmental disability needs of the clients as specified in the treatment/habilitation plan. The Program Coordinator: -Date of hire was 9/20/20. -No documentation of training to meet the mental health and developmental disability needs of the clients as specified in the treatment/habilitation plan. Interviews on 8/22/22 and 8/24/22 with staff #1 revealed: -She was employed with the facility for a little over 2 years. -She worked alone with the clients during her shift. -She had no recent training in CPR. -She thought she received the CPR training when she was hired. -She couldn't remember if the CPR training was done online. Interview on 8/23/22 with staff #2 revealed: -She left the agency in December 2021 and returned to the facility in April 2022. -She mainly worked weekends at the facility. She worked alone with the clients during her shift. -She thought she did FA and CPR training towards the end of 2021. -She couldn't remember if the FA and CPR trainings were done online. Interview on 8/23/22 with the Program Coordinator revealed: -It was her responsibility as Program Coordinator to ensure staff received the required trainings. -She was responsible for ensuring staff received FA and CPR training. -The Director/Licensee scheduled all of the	V 108		

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V 108	Continued From page 4 trainings for staff. -She didn't know any trainers or have any of those trainers contact information. -"[The Director/Licensee] will not let any one else schedule those trainings, she does it all herself." Interview on 8/23/22 with the Director/Licensee revealed: -Staff worked alone with the clients during their shifts at the facility. -She thought the FA and CPR trainings for some staff was done online due to Covid. -The instructor conducting the training said it could be done online if those staff were previously certified in FA and CPR. She didn't realize staff could not be trained online for CPR. -She didn't realize staff were supposed to receive training to meet the mental health and developmental disability needs of clients. -The Program Coordinator was responsible for ensuring staff were scheduled for the FA and CPR trainings. -She confirmed staff #1 and staff #2 had no training in CPR. -She confirmed staff #2 had no training in FA. -She confirmed staff #1, staff #2 and the Program Coordinator had no documentation of training to meet the mental health and developmental disability needs of the clients as specified in the treatment/habilitation plan. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type B rule violation and must be corrected within 45 days.	V 108		
V 110	27G .0204 Training/Supervision Paraprofessionals	V 110		

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V 110	Continued From page 5 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; (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 and interviews two of five staff (the Program Coordinator and the Director/Licensee) failed to demonstrate the knowledge, skills and abilities required for the	V 110		

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V 110	Continued From page 6 population served. The findings are: Review on 8/23/22 and 8/24/22 of the facility's personnel records revealed the following: Program Coordinator: -Date of hire was 9/20/20. Director/Licensee: -Date of hire was 8/2005. 1. The Director/Licensee failed to demonstrate good decision making by allowing client #2 to be unsupervised in the community. Program Coordinator failed to ensure safety of client #2 by waiting to contact police department after that individual was missing for two days. Review on 8/22/22 of client #2's record revealed: -Admission date of 8/11/22. -Diagnoses of Schizoaffective Disorder-Bipolar Type, Obesity, Cocaine Use Disorder, Cannabis Use Disorder and Type II Diabetes, History of Seizure Disorder and Vitamin D Deficiency. Review on 8/23/22 of an incident report 8/22/22 revealed: -"On last Friday, August 19 [Client #2] left the home reporting that she was going to get her hair done. Staff alerted [Program Coordinator] on Saturday morning that she did not return. [Program Coordinator] contacted her mother, called hospitals and the jail in hopes of contacting [client #2]. Her mother reported that she frequented an area of [local city] and [Program Coordinator] went there checking on her. After looking for her and allowing 24 hours to pass a missing person report was filed. [Client #2] returned to the home on this morning, August 22, 2022."	V 110		

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V 110	Continued From page 7 Interview on 8/22/22 with client #2 revealed: -She walked away from the facility last Friday August 19, 2022. She returned to the facility this morning August 22, 2022. -She left the facility and caught the bus to her Aunt's house. -She went to her Aunt's house to get her hair done. -The Director/Licensee gave her permission to get her hair done. -She went to visit her Aunt. She got into a car accident with her Aunt while she was on her visit. -She could not specify where they were when the accident occurred, they were in the local area. -She could not give any other details about the accident. -She hurt her knee in the car accident. Her body was a little sore and swollen. -She was in the hospital from Friday August 19, 2022 until Monday August 22, 2022. -Her Uncle dropped her off at the bus station Monday morning after being discharged from the hospital. -She walked back to the facility Monday morning around 7:45 am. It took her about 30 minutes to walk to the facility. -She left the discharge paperwork from the hospital at her Aunt's house. -She didn't know her Aunt's number and she could not remember the name of the hospital. She knew the hospital was in the local area. Interview on 8/23/22 with staff #2 revealed: -She called the Director/Licensee on Friday August 19, 2022 when client #2 decided she was going to her Aunt's home. Client #2 said she wanted to get her hair done. -The Director/Licensee gave client #2 permission over the phone to get her hair done.	V 110		

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V 110	Continued From page 8 -She thought client #2 left the facility around 3:00 pm. -She tried calling client #2's mother around 9:00 pm when client #2 failed to return. -Client #2's mother tried to contact the Aunt and was not able to locate her or client #2. -Client #2's mother said she would call back later and her mother never called back after that. -She worked the entire weekend and client #2 did not return Saturday or Sunday. -She stayed in constant contact with the Program Coordinator about the incident with client #2. -The Program Coordinator came over on Sunday August 21, 2022. The Program Coordinator did a report to the police department that client #2 was missing. -Client #2 came back on her own the morning of August 22, 2022 around 7:30 am. Interviews on 8/22/22 and 8/23/22 with the Program Coordinator revealed: -When she came in on Friday August 19, 2022 around 3:00 pm, staff #2 informed her client #2 had just walked off. -Client #2 told staff #2 she was going to get her hair done. -She drove to places throughout the weekend she thought client #2 could possibly be. She could not locate client #2. -She thought client #2 caught the bus to wherever she went. -Client #2 knew the area because she was from the local city. -They called hospitals and jails prior to client #2 showing up and she could not be located. -They were not sure where client #2 was over the weekend. Client #2 had a history of substance abuse and a criminal record. -She contacted the Director/Licensee about client #2 not returning to the facility on Saturday	V 110		

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morning.
-She did not call the police department to report client #2 missing until Sunday even though client #2 left on Friday. "It was my understanding [client #2] could not be reported missing until 48 hours later."
-The police officers were not able to locate client #2 in the community.
-Staff #2 called her the morning of August 22, 2022 and said client #2 showed up around 7:25 am.
-Client #2 told them she was in the hospital over the weekend.

Interviews on 8/22/22 and 8/23/22 with the Director/Licensee revealed:
-Client #2 resided at the facility for about 2 weeks.
-Client #2 had unsupervised time approved, however she told her it was not to start until she was in the facility for 30 days.
-She knew client #2 left the facility on August 19, 2022 and returned on August 22, 2022.
-Prior to the incident she told client #2 she could not sign herself out in order to get her hair done. Client #2 wanted to go to visit her Aunt in the community and get her hair done.
-When she was on the phone with client #2 she told her she could not leave the facility to get her hair done without staff being with her.
-She thought the issue was "squashed" after speaking with client #2 about not leaving the facility unsupervised.
-She didn't give client #2 permission to go to her Aunt's house to get her hair done.
-According to staff #2, client #2 left the facility without permission.
-The Program Coordinator sent her a text Saturday morning stating "[client #2] was absent without official leave (AWOL) and she is on top of

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V 110	Continued From page 10 it." -She was not available over the weekend and the Program Coordinator handled that incident with client #2 leaving the facility unsupervised. -When client #2 returned on August 22, 2022 she said she got into a car accident with her Aunt while they were out in the community. -Client #2 said she was in the hospital over the weekend. -Client #2 was from the local area and she felt like she knew the area. -She didn't think client #2 was in the hospital. She really wasn't sure where client #2 was over the weekend. 2. The Program Coordinator and the Director/Licensee failed to ensure staff had trainings as required. Refer to V108, V536, 537 for more details related to staff trainings: -Staff #1's Cardiopulmonary Resuscitation (CPR) training was completed online. -Staff #2 had no documentation of First Aid (FA) or CPR training. -Staff #1, staff #2, Qualified Professional and Program Coordinator had no documentation of current training in National Crisis Intervention + (NCI+). -Staff #1, staff #2 and the Program Coordinator had no training to meet the mental health and developmental disability needs of clients. 3. The Program Coordinator and the Director/Licensee failed to ensure staff had the required documentation in their personnel record. Refer to V131 and V133 for more details related to staff required documentation for personnel records.	V 110		

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V 110	Continued From page 11 -Staff #1's Health Care Personnel Registry (HCPR) was not accessed prior to hire. -Staff #2's HCPR was not accessed when she was rehired in April 2022. -Staff #1's criminal history record check had no date. -Staff #2's criminal history record check was not requested when she was rehired in April 2022. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type B rule violation and must be corrected within 45 days.	V 110		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure fire and disaster drills were done quarterly on each shift. The findings are:	V 114		

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V 114	Continued From page 12 Review on 8/22/22 of the facility's fire drill log revealed: -8/15/22-1st shift -7/14/22-2nd shift -6/1/22-1st shift -5/18/22-1st shift -4/13/22-1st shift -3/29/22-2nd shift -There was no documentation of staff conducting a fire drill on 2nd and 3rd shifts during the 2nd quarter. Review on 8/22/22 of the facility's disaster drill log revealed: -7/29/22-1st shift -7/15/22-1st shift -6/4/22-2nd shift -5/28/22-2nd shift -4/18/22-1st shift -3/22/22-1st shift -There was no documentation of staff conducting a disaster drill on 3rd shift during the 2nd quarter. Interview on 8/23/22 with client #1 revealed: -They did a fire drill this morning with staff. -She thought they did a disaster drill about 2-3 months ago. -She thought they did fire and disaster drills about every 2-3 months with them. Interview on 8/22/22 with the Director/Licensee revealed: -The facility had three separate staff shifts. -She didn't know staff were not conducting the fire and disaster drills consistently. -She confirmed staff failed to ensure fire and disaster drills were done quarterly on each shift. This deficiency constitutes a re-cited deficiency	V 114		

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V 114	Continued From page 13 and must be corrected within 30 days.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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This Rule is not met as evidenced by:
Based on observation, record reviews and interviews, the facility failed to keep the MARs current affecting one of two current audited clients (#1) and one of one former client (FC #5). The findings are:

a. Review on 8/22/22 of client #1's record revealed:
-Admission date of 2/14/19.
-Diagnoses of Schizoaffective Disorder, Hypersalivation, Tachycardia, Nephrogenic Diabetes Insipidus, Osteopenia, Overweight, Vitamin D deficiency, Hyperlipidemia and Tinea Pedis.

Review on 8/23/22 of physician's orders for client #1 revealed:
-Order dated 2/16/22 for Melatonin 3 milligrams (mg) (Sleep Disorders), one or two tablets nightly about 30 minutes before bedtime and Ipratropium Nasal Spray 21 micrograms (mcg) (Drooling), place two sprays under tongue three times daily as needed.

Observation on 8/23/22 at approximately 10:26 am of the medication area revealed:
-Melatonin and Ipratropium Nasal Spray were both available for client #1.

Review on 8/23/22 of the July 2022 MAR for client #1 revealed:
-The medications above were not listed.

b. Review on 8/22/22 of FC #5's record revealed:
-Admission date of 4/16/14.
-Diagnoses of Schizophrenia-Paranoid Type, Osteopenia, Chronic Obstructive Pulmonary

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V 118	Continued From page 15 Disease and Tobacco Use Disorder. -Discharge date of 8/16/22. Review on 8/22/22 of physician's orders revealed: -Order dated 5/23/22 for Clonazepam 0.5 mg (Panic Disorder and Anxiety), one tablet at bedtime and Haloperidol 5 mg (Psychotic Disorders), one tablet at bedtime. -Order dated 2/10/22 for Benztropine Mesylate 1 mg (Parkinson's Disease or Involuntary Movements), one tablet at bedtime. Review on 8/22/22 of the June 2022 MAR for client #2 revealed: -Staff failed to put their initial's as administered on the MAR for the following medications: -On 6/30/22 for Clonazepam 0.5 mg, Haloperidol 5 mg and Benztropine Mesylate 1 mg. Interview on 8/23/22 with staff #2 revealed: -Client #1 was administered the Melatonin every night as prescribed during her shift. -Client #1 didn't take the spray for drooling. -Staff were documenting the Melatonin was given in July 2022. -She wasn't sure why the MAR was no longer in client #1's record. Interviews on 8/22/22 and 8/23/22 with the Program Coordinator revealed: -Clients got their medications as prescribed. -There was a second sheet that had the Melatonin and Ipratropium Nasal Spray listed for client #1 in July 2022. -She would normally take the older MARs out of the MAR book and put them into the clients record books. -She thought she was out sick one day and another staff took the July 2022 MARs out of the MAR book.	V 118		

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V 118	Continued From page 16 -She wasn't sure why the July MAR for client #1 that listed the Melatonin and Ipratropium Nasal Spray wasn't in her record book. -She thought staff forgot to sign the June 2022 MAR to indicate the medications were administered for FC #5. -"That was my fault, I should have caught that." -She was responsible for checking the MARs to ensure there are no issues. -She confirmed staff failed to keep the MARs current for client #1 and FC #5. Interview on 8/23/22 with the Director/Licensee revealed: -Staff administered the prescribed medications to client #1 and FC #5 daily. -She spoke with the Program Coordinator about second page of the July 2022 MAR for client #2. -The Program Coordinator said she wasn't sure what happened to the second page of client #2's July MAR. -The Program Coordinator was responsible for checking MARs for medication errors. -She confirmed staff failed to keep the MARs current for client #1 and FC #5. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type B rule violation and must be corrected within 45 days.	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 121		

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V 121	Continued From page 17 REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to obtain drug regimen reviews every six months for one of one former client (Former Client #5) who received psychotropic drugs. The findings are: Review on 8/22/22 of FC #5's record revealed: -Admission date of 4/16/14. -Diagnoses of Schizophrenia-Paranoid Type, Osteopenia, Chronic Obstructive Pulmonary Disease and Tobacco Use Disorder. -Discharge date of 8/16/22. -Drug regimen review was completed on 11/12/21. -Medication Form dated 5/17/22-Pharmacist wrote "MRR (Medication Regimen Review)-note on file-emailed to facility." Review on 8/22/22 of physician's orders revealed: -Order dated 5/23/22 for Clonazepam 0.5 milligrams (mg) (Panic Disorder and Anxiety), one	V 121		

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V 121	Continued From page 18	V 121		

tablet at bedtime and Haloperidol 5 mg (Psychotic Disorders), one tablet at bedtime.

Review on 8/22/22 of the Medication Administration Record (MAR) revealed:
-July 2022-Staff documented FC #5 was administered the above medications for the entire month.
-June 2022-Staff documented FC #5 was administered the above medications for the entire month.

Review on 8/22/22 of facility records revealed:
-There was no evidence of a current drug regimen review completed within the last six months for FC #5.

Interview on 8/22/22 with the Program Coordinator revealed:
-The pharmacist emailed the psychotropic drug regimen review to the Director/Licensee for FC #5.
-She didn't think the Director/Licensee opened the email when the pharmacist sent that document to her.
-Initially, she didn't know the document was emailed until she just looked at the document in FC #5's client record.
-She confirmed there was no documentation of a drug regimen review completed for FC #5 within the last six months.

Interview on 8/24/22 with the Director/Licensee revealed:
-She didn't realize the Pharmacist emailed FC #5's psychotropic drug regimen review to her in May 2022.
-The Program Coordinator was responsible for those psychotropic drug regimen reviews. That psychotropic drug regimen review for FC #5

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V 121	Continued From page 19 should have been emailed to the Program Coordinator. -She confirmed there was no documentation of a drug regimen review completed for FC #5 within the last six months.	V 121		
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 reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to employment affecting two of four audited staff (#1 and #2). The findings are: Review on 8/23/22 of the facility's personnel records revealed the following: Staff #1: -No date of hire. -Hired as a Habilitation Technician. -No documentation the HCPR was accessed prior to employment.	V 131		

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V 131	Continued From page 20 Staff #2: -No date of hire. -Hired as a Habilitation Technician. -HCPR was accessed on 9/30/20. -No documentation the HCPR was accessed when she was rehired in April 2022. Interview on 8/22/22 with staff #1 revealed: -She was employed with the facility for a little over 2 years. Interview on 8/23/22 with staff #2 revealed: -She left the agency in December 2021 and returned to the facility in April 2022. Interview on 8/23/22 with the Program Coordinator revealed: -It was her responsibility as the Program Coordinator to ensure staff had the required documentation in their personnel folders. -She was responsible for making sure the HCPR was accessed for all staff. Although it was her responsibility, the Director/Licensee would access the HCPR for staff. Interviews on 8/23/22 and 8/24/22 with the Director/Licensee revealed: -She thought the HCPR was accessed for staff #1. -Staff #2 just returned to the agency in April 2022. She didn't realize she was supposed to access the HCPR for staff #2 when she rehired her. -The Program Coordinator was responsible for ensuring the HCPR checks were completed for staff. -She did the HCPR in the past for some staff because the Program Coordinator was not available. -She confirmed the facility failed to ensure the HCPR was accessed for staff #1 and staff #2	V 131		

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V 131	Continued From page 21 prior to employment. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type B rule violation and must be corrected within 45 days.	V 131		
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	V 133		

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V 133	Continued From page 22 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 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	V 133		

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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:
(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

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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 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

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V 133	Continued From page 25 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. (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 ensure the criminal history record check was requested within five business days of making the conditional offer of employment	V 133		

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V 133	Continued From page 26 affecting two of four audited staff (#1 and #2). The findings are: Review on 8/23/22 of the facility's personnel records revealed the following: Staff #1: -No date of hire. -Hired as a Habilitation Technician. -Criminal history record check had no date indicated. Staff #2: -No date of hire. -Hired as a Habilitation Technician. -Criminal history record check was requested on 9/30/20. -No documentation a criminal history record check was requested when she was rehired in April 2022. Interview on 8/22/22 with staff #1 revealed: -She was employed with the facility for a little over 2 years. Interview on 8/23/22 with staff #2 revealed: -She left the agency in December 2021 and returned to the facility in April 2022. Interview on 8/23/22 with the Program Coordinator revealed: -It was her responsibility as Program Coordinator to ensure staff had the required documentation in their personnel folders. -She was responsible for making sure the criminal history record check was requested for staff. Although it was her responsibility the Director/Licensee would request the criminal history checks for staff.	V 133		

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V 133	Continued From page 27 Interviews on 8/23/22 and 8/24/22 with the Director/Licensee revealed: -She wasn't sure why staff #1's criminal history check was not dated. -Staff #2 just returned to the agency in April 2022. She didn't realize she was supposed to request the criminal history record check for staff #2 when she rehired her. -She thought the Qualified Professional and Program Coordinator were both responsible for the criminal history record checks. -She did the criminal background in the past because it was not completed by the Qualified Professional or Program Coordinator. -She confirmed the facility failed to ensure the criminal history record check was requested within five business days of making the conditional offer of employment for staff #1 and staff #2. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type B rule violation and must be corrected within 45 days.	V 133		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or	V 289		

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V 289	Continued From page 28 (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205	V 289		

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V 289	Continued From page 29 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to operate within the scope of the program developed and designed to provide services for habilitation/rehabilitation, care and supervision affecting four of four current clients (#1, #2, #3 and #4) and one of one former client (FC #5) The findings are: Cross Reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (Tag 108) Based on record reviews and interviews, the facility failed to ensure two of four audited staff (#1 and #2) had training in Cardiopulmonary Resuscitation (CPR); one of four audited staff (#2) had training in First Aid (FA) and three of four audited staff (#1, #2 and Program Coordinator) had training to meet the mental health and developmental disability needs of the clients as specified in the treatment/habilitation plan. Cross Reference: 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (Tag 110) Based on record reviews and interviews two of five staff (the Program Coordinator and the Director/Licensee) failed to demonstrate the knowledge, skills and abilities required for the	V 289		

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V 289	Continued From page 30 population served. Cross Reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (Tag 118) Based on observation, record reviews and interviews, the facility failed to keep the MAR current affecting one of two current audited clients (#1) and one of one former client (FC #5). Cross Reference: G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (Tag 131) Based on record reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to employment affecting two of four audited staff (#1 and #2). Cross Reference: G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT (Tag 133) Based on record reviews and interviews, the facility failed to ensure the criminal history record check was requested within five business days of making the conditional offer of employment affecting two of four audited staff (#1 and #2). Cross Reference: 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (Tag 536) Based on record reviews and interviews, the facility failed to ensure four of four audited staff (#1, #2, Program Coordinator and Qualified Professional) had training on the use of alternatives to restrictive interventions. Cross Reference: 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (Tag 537)	V 289		

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V 289	Continued From page 31 Based on record reviews and interviews, the facility failed to ensure four of four audited staff (#1, #2, Program Coordinator and Qualified Professional) had training in the use of seclusion, physical restraints and isolation time-out training. a. Review on 8/22/22 of client #1's record revealed: -Admission date of 2/14/19. -Diagnoses of Schizoaffective Disorder, Hypersalivation, Tachycardia, Nephrogenic Diabetes Insipidus, Osteopenia, Overweight, Vitamin D deficiency, Hyperlipidemia and Tinea Pedis. -Client #1 had no documentation that indicated a diagnosis of a developmental disability. b. Review on 8/22/22 of client #2's record revealed: -Admission date of 8/11/22. -Diagnoses of Schizoaffective Disorder-Bipolar Type, Obesity, Cocaine Use Disorder, Cannabis Use Disorder and Type II Diabetes, History of Seizure Disorder and Vitamin D Deficiency. -Client #2 had no documentation that indicated a diagnosis of a developmental disability. c. Review on 8/22/22 of client #3's record revealed: -Admission date of 7/29/19. -Diagnoses of Schizophrenia, Hypertension, Hyperlipidemia, Morbid Obesity, Vitamin D Deficiency and Normocytic Anemia. -Client #3 had no documentation that indicated a diagnosis of a developmental disability. d. Review on 8/22/22 of client #4's record revealed: -Admission date of 12/27/19. -Diagnoses of Schizoaffective Disorder-Bipolar	V 289		

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V 289	Continued From page 32	V 289		

type, Hypertension, Coronary Artery Disease, Type II Diabetes, Nonrheumatic Aortic Valve Insufficiency and History of Ascending Aortic Aneurysm.
-Client #4 had no documentation that indicated a diagnosis of a developmental disability.

e. Review on 8/22/22 of FC #5's record revealed:
-Admission date of 4/16/14.
-Diagnoses of Schizophrenia-Paranoid Type, Osteopenia, Chronic Obstructive Pulmonary Disease and Tobacco Use Disorder.
-Discharge date of 8/16/22.
-FC #5 had no documentation that indicated a diagnosis of a developmental disability.

Interviews on 8/22/22 and 8/24/22 with the Director/Licensee revealed:
-She acknowledged none of the clients had a documented developmental disability diagnosis.
-An assessment was done in the past for clients #1, #3, #4 and FC #5 by the psychiatrist.
-The facility never received any type of paperwork to reflect those clients having a developmental disability diagnosis.
-Client #2 was just admitted to the facility about 2 weeks ago, she was still trying to get some additional paperwork for her.
-She reached out to the Local Management Entity/Managed Care Organization (LME/MCO) after the March 2022 survey.
-She was inquiring about a letter of support for clients whose primary diagnosis was mental illness. The person she spoke with from the LME/MCO said there were no letters of support available for that service category.
-She confirmed the facility failed to operate within the scope of the licensure.

Review on 8/24/22 of a Plan of Protection written

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V 289	Continued From page 33 by the Qualified Professional and the Director/Licensee dated 8/24/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? [The Director/Licensee] and [the Qualified Professional] will meet with staff immediately to ensure that there is a clear understanding of how to ensure consumers are safe. Staff will receive training in how to deal with Mental Illness and Developmentally disable consumers. This training will be provided by [Qualified Professional]. Staff will receive training manage to include the correct way of completing MAR (Medication Administration Record). Staff will be scheduled to completed First Aid and CPR (Cardiopulmonary Resuscitation) training. The certificates to confirm verification of completion of NCI (National Crisis Intervention) will be completed. [The Qualified Professional] will complete criminal history checks and Health Care Registry on each staff member. [The Director/Licensee] will again contact [the Local Management Entity/Managed Care Organization] to request a letter of support for a Mental Illness licensure. Consumer who recently left the facility will no longer have unsupervised time in the community. Describe your plans to make sure the above happens. Moving forward a tracking system will be implemented to ensure that certifications do not expire. A policy will be implemented to address consumer's walking away and staff will be update on this policy immediately. Staff meetings will be held more often to ensure that there is consistency in understanding Melody House policies and procedures regarding consumers." The facility served clients whose diagnoses included: Schizoaffective Disorder, Schizophrenia, Diabetes, Nephrogenic Diabetes Insipidus, Coronary Artery Disease,	V 289		

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V 289	Continued From page 34 Nonrheumatic Aortic Valve Insufficiency, Ascending Aortic Aneurysm, Chronic Obstructive Pulmonary Disease, Seizure Disorder, Hypertension, Hyperlipidemia, Cocaine Use Disorder and Cannabis Use Disorder. None of the clients residing at this facility had a diagnosis of Developmental Disability. Client #2 left the facility without permission on August 19, 2022 and returned on August 22, 2022. The Director/Licensee and Program Coordinator failed to contact the police department until August 21, 2022 to report client #2 missing. Facility staff (#1 and #2) who worked alone in the facility failed to have documentation of training in CPR, First Aid, client specific needs, alternatives to restrictive intervention and Restrictive Interventions and Seclusion, Physical Restraint and Isolation time-out. The Program Coordinator and Qualified Professional also had no documentation of training in Alternatives to Restrictive Interventions and Seclusion, Physical Restraint and Isolation time-out. Either the Director/Licensee or Program Coordinator was responsible for ensuring all staff trainings were current and personnel records included the required documentation that training was completed. The Medication Administration Records for client #1 and FC #5 were not kept current by staff. Staff misplaced the 2nd page to the July 2022 MAR for client #1 which listed Melatonin to be administered daily and Ipratropium Nasal Spray to be given as needed. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. 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 289		

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V 536	Continued From page 35	V 536		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served;	V 536		

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V 536	Continued From page 36 (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence	V 536		

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

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V 536	Continued From page 38 (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 reviews and interviews, the facility failed to ensure four of four audited staff (#1, #2, Program Coordinator and Qualified Professional) had training on the use of alternatives to restrictive interventions. The findings are: Review on 8/23/22 of the facility's personnel records revealed the following: Staff #1: -No date of hire. -Hired as a Habilitation Technician. -National Crisis Intervention + (NCI+) training was completed on 7/29/21. -No documentation of current training on the use of alternatives to restrictive interventions. Staff #2:	V 536		

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-No date of hire.
-Hired as a Habilitation Technician.
-NCI + training was completed on 7/29/21.
-No documentation of current training on the use of alternatives to restrictive interventions.

Program Coordinator:
-Date of hire was 9/20/20.
-NCI+ training was completed on 7/29/21.
-No documentation of current training on the use of alternatives to restrictive interventions.

Qualified Professional:
-Date of hire was 5/6/15.
-NCI+ training was completed on 10/2/20.
-No documentation of current training on the use of alternatives to restrictive interventions.

Interviews on 8/22/22 and 8/24/22 with staff #1 revealed:
-She was employed with the facility for a little over 2 years.
-She thought they did NCI+ training a few months ago.

Interview on 8/23/22 with staff #2 revealed:
-She left the agency in December 2021 and returned to the facility in April 2022.
-She had NCI+ training, she thought the training was completed a few months ago.

Interview on 8/23/22 with the Program Coordinator revealed:
-It was her responsibility as Program Coordinator to ensure staff received the required trainings.
-She was responsible for ensuring staff had training in NCI+.
-The Director/Licensee scheduled all of the trainings for staff.
-She didn't know any trainers or have any of

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	MHL032-498	A. BUILDING: _____ B. WING _____	R 08/24/2022

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V 536	Continued From page 40 those trainer's contact information. -"[The Director/Licensee] will not let any one else schedule those trainings, she does it all herself." -She thought all staff did the NCI+ training a few months ago. Interviews on 8/23/22 and 8/24/22 with the Director/Licensee revealed: -The agency used NCI+ for training on the use of alternatives to restrictive interventions. -The Program Coordinator was responsible for ensuring staff were scheduled for NCI+ training. -She thought all staff did a recent NCI+ training, however she could not locate the training certificates for staff. -She confirmed there was no documentation of training on the use of alternatives to restrictive interventions for staff #1, staff #2, Program Coordinator and Qualified Professional. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type B rule violation and must be corrected within 45 days.	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.	V 537		

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V 537	Continued From page 41 (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (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;	V 537		

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V 537	Continued From page 42 (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence 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.	V 537		

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V 537	Continued From page 43 (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (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:	V 537		

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V 537	Continued From page 44 (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure four of four audited staff (#1, #2, Program Coordinator and Qualified Professional) had training in the use of seclusion, physical restraints and isolation time-out training. The findings are: Review on 8/23/22 of the facility's personnel records revealed the following: Staff #1: -No date of hire. -Hired as a Habilitation Technician. -National Crisis Intervention + (NCI+) Defensive training was completed on 7/29/21. -No documentation of current training in the use of seclusion, physical restraints and isolation time-out. Staff #2: -No date of hire. -Hired as a Habilitation Technician. -NCI+ Defensive training was completed on 7/29/21. -No documentation of current training in the use	V 537		

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V 537	Continued From page 45 of seclusion, physical restraints and isolation time-out. Program Coordinator: -Date of hire was 9/20/20. -NCI+ Defensive training was completed on 7/29/21. -No documentation of current training in the use of seclusion, physical restraints and isolation time-out. Qualified Professional: -Date of hire was 5/6/15. -No documentation of training in the use of seclusion, physical restraints and isolation time-out for staff #1. Interviews on 8/22/22 and 8/24/22 with staff #1 revealed: -She was employed with the facility for a little over 2 years. -She thought they did NCI+ training a few months ago. Interview on 8/23/22 with staff #2 revealed: -She left the agency in December 2021 and returned to the facility in April 2022. -She had NCI+ training, she thought the training was completed a few months ago. Interview on 8/23/22 with the Program Coordinator revealed: -It was her responsibility as Program Coordinator to ensure staff received the required trainings. -She was responsible for ensuring staff had training in NCI+. -The Director/Licensee scheduled all of the trainings for staff. -She didn't know any trainers or have any of those trainer's contact information.	V 537		

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