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	MHL0601400	A. BUILDING: _____ B. WING _____	11/02/2022

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SMITH COTTAGE	6725 SAINT PETER'S LANE MATTHEWS, NC 28105

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on November 2, 2022. One complaint was substantiated (Intake #NC00193846). Three complaints were unsubstantiated (Intake #NC00190326, #NC00192270, #NC00192276). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. This facility is licensed for 9 and currently has a census of 7. The survey sample consisted of audits of 3 current clients, 3 former clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include:	V 105		

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V 105	Continued From page 1 (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to follow the discharge policy affecting 2 of 3 former clients (FC) (#5, #6). The findings are:

Review on 8/30/22 of FC #5's record revealed:
- Admission date 4/29/22;
- Age 15;
- Diagnoses- Post Traumatic Stress Disorder; Conduct Disorder, adolescent onset type;
- Discharge date 7/7/22;
- No discharge summary in record.

Review on 8/30/22 of FC#6's record revealed:
- Admission date 3/9/22;
- Age 16;
- Diagnosis- Post Traumatic Stress Disorder, unspecified;
- Discharge date 7/12/22;
- No discharge summary in record.

Review on 10/4/22 of the facility's policy titled Discharge Policy Revised on 3/23/17 revealed:
-" ... Therapist will complete the discharge summary in Echo(electronic medical record) within 72 hours of a client discharging."

Interview on 10/4/22 with the Quality Improvement Specialist revealed:
- Discharge summaries were not completed for former clients #5 and #6;

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V 105	Continued From page 3 - The therapist was responsible for completing discharge summaries; - There were no therapist during the time of discharge of FC #5 and FC #6 Interview on 11/2/22 with the Residential Program Director revealed: -The therapist was responsible for completing discharge summaries, but case managers are now responsible for discharge summaries.	V 105		
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 4 (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 interviews the facility failed to ensure training in client rights and meeting the mh/dd/sa needs of the client as specified in the treatment/habilitation plan affecting 1 of 4 current paraprofessional staff (staff #1). The findings are: Review on 9/23/22 of staff #1's personnel record revealed: - Hire date 5/16/22; - No documentation that clients rights, mh/dd/sa trainings specified in each client's treatment plan were completed. Interview on 9/22/22 with staff #1 revealed: - "I have not had my Care (Children and Residential Experience) training." Interview on 10/7/22 with the Quality Improvement Specialist revealed: - Human Resources registered staff on the Relias(electronic training) training system; - Supervisors were responsible for making sure staff were registered on the Relias training application and informing staff to complete training. - CARE training was the agency's client specific training.	V 108		

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V 108	Continued From page 5 Interview on 11/2/22 with the Residential Program Director revealed: - CARE was a 5 day training; - CARE training was completed within 90 days of hire.	V 108		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge.	V 119		

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V 119	Continued From page 6	V 119		

This Rule is not met as evidenced by:
Based on record reviews, observations, and interviews, the facility failed to ensure medication was disposed of in a manner that guards against diversion or accidental ingestion affecting 3 of 3 audited clients. The following are:

Review on 8/30/22 of client #1's record revealed:
- Admission date 6/29/22;
- Age 15;
- Diagnosis- Posttraumatic Stress Disorder, with disassociative symptoms;
Personal history (past history) of sexual abuse in childhood, Personal history of self-harm;
- Physician order-Acetaminophen(pain reliever) 500 milligrams(mg) tablets, Take 1 tablet by mouth every four hours as needed for pain/fever 6/29/22.

Review on 8/30/22 of client #2's record revealed:
- Admission date 3/7/22;
- Age 16;
- Diagnoses- Major Depressive Disorder, recurrent severe without psychotic features, Disruptive Mood Dysregulation Disorder;
- Physician order-Acetaminophen(pain reliever) 500 mg tablets, Take 1 tablet by mouth every four hours as needed for pain/fever 3/9/22.

Review on 8/30/22 of client #3's record revealed:
- Admission date 4/19/22;
- Age 15;
- Diagnoses- Oppositional Defiant Disorder, Disruptive Mood Dysregulation Disorder, Bipolar Disorder, Current Episode Manic without Psychotic Features, Unspecified;
- Physician order- Acetaminophen(pain reliever)

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V 119	Continued From page 7	V 119		

500 mg tablets,Take 1 tablet by mouth every four hours as needed for pain/fever 4/23/22.

Observations on 8/31/22 at approximately 3:18pm of the over the counter (OTC) stock medications revealed:
- Acetaminophen 500 mg tablets, OTC expired 6/9/22.

Review on 8/31/22 of client #1's MAR from June 2022-August 2022 revealed:
- Client #1 was administered Acetaminophen 500mg in July 2022 on 7/12, 7/22, 7/24, 7/26, 7/27.

Review on 8/31/22 of client #2's MAR from June 2022-August 2022 revealed:
- Client #2 was administered Acetaminophen 500 mg in June 2022 on 6/22, 6/24-6/26; July 2022 on 7/2, 7/11, 7/19, 7/20, 7/28.

Review on 8/31/22 of client #3's MAR from June 2022-August 2022 revealed:
- Client #3 was administered Acetaminophen 500mg in June 2022 on 6/12, 6/13, 6/15, 6/16,6/17, 6/23, 6/26; July 2022 on 7/9 7/21; August 2022 on 8/20, 8/21, 8/26-8/28.

Interview on 8/31/22 with the Registered Nurse #12 revealed:
- Unaware the medication expired;
- Removed the acetaminophen from the rest of the medications on 8/31/22.

Interview on 11/2/22 with the Registered Nurse Supervisor #15 revealed:
- Night shift nurses checked the medications;
- OTC medications are checked every other month at the first of the month;

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V 119	Continued From page 8 - Unaware there was an expired medication.	V 119		
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential to facilitate treatment. (f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1,	V 314		

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V 314	Continued From page 9 Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on the record reviews, observation and interviews, the facility failed to provide a structured living environment for children who required supervision and specialized interventions on a 24-hour basis, affecting 1 of 3 audited client (client #1). The findings are: Review on 8/30/22 of client #1's record revealed: - Admission date 6/29/22; - Age 15; - Diagnoses- Posttraumatic Stress Disorder, With Dissociative Symptoms Personal history (past history) of sexual abuse in childhood, Personal history of self-harm. Review on 10/7/22 of the facility's Incident Report dated 10/2/22 revealed: - Staff documenting incident: Program Supervisor; - "What happened? Around 11:00 AM, [client #1]came out of his room and began saying "goodbye" to his peers. As [staff #5]begin inquiring with [client #1], [client #1] expressed that he stole a bottle of melatonin from the nurses area without telling anyone the night before.	V 314		

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V 314	Continued From page 10 [Client #1] then told [staff #5] that he swallowed multiple of the melatonin pills at once. When staff asked when he did this, he said 10 minutes prior. [Staff #5] immediately alerted the nurse who alerted the physician. The nurse then called 911 and medics for a transport to a local hospital. [Client #1] was transported to local hospital. [Client #1] was admitted for further psychiatric evaluation and medical treatment." Review on 10/7/22 of the facility's Investigation Report dated 10/3/22 revealed: - Investigation completed by Quality Improvement Specialist (QIS) - "Incident (10/1/22)- Chief Performance and Quality Officer contacted QIS to complete a root cause analysis of the incident that took place in the cottage over the weekend of 10/1/22-10/2/22 involving a client gaining access to the med (medication) closet; - Pre-Investigation Actions- Review camera footage on 10/1/22 on Verkada System (monitoring system) (Smith Common Area 1), spoke to Nurse Manager to obtain timeframe for the incident, noted that client (client #1) was unable to be interviewed due to hospitalization; - Evidenced/Documents Reviewed-Camera footage was viewed on Verkada system for evening of 10/1 (Smith Common Area 1) 7:58-8:07pm; - Other Actions Taken- Communicated with Program Supervisor to identify staff present during the incident on 10-1; -Conclusion- Based on camera review it was determined that the client was able to gain access to the med closet because the door was left open by the nurse on duty and clients were not being adequately supervised by staff. There was another client (client #3) in crisis at the time of the incident and the staff and nurse were with	V 314		

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V 314	Continued From page 11 that client." Review on 10/27/22 of the Employee Notes Report written by the Program Supervisor revealed: "Reason: Incident 10.01 Follow Up-Feedback/Coaching Date: 10/06/2022 Core Values and Skills: Shared With: Employee + Manager Description: Program Supervisor spoke with [staff #4] to discuss the incident from 10.01. Program Supervisor gave [Staff #4] direct feedback about not using her personal phone on the floor. The Program Supervisor gave [staff #4] the feedback from the follow up memo in regard to the Incident involving [client #1] and the med closet from 10.01. The Program Supervisor Discussed supervision of the milieu while a client is in crises. [Staff #4] was receptive to the feedback and debriefed the incident well." Review on 11/1/22 of the facility's video surveillance time stamped on 10/1/22 revealed: Smith Common Area 1: 9 minutes of video surveillance from 7:58-8:07pm: - Client #1 was in the hallway with client #2; - Client #1 came to the common area and sat in the chair; - Staff #4 came into the common area and sat in a chair straight across from the medicine closet; - Client #1 walked over to the medicine closet and looked inside; - Client #1 then walked back down the hallway and spoke with client #2; - Client #1 returned to the medicine closet, looked around from outside of the door; - Client #1 walked around the area of the medicine closet and looked in staff #4's direction;	V 314		

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V 314	Continued From page 12 - Client #1 stood in front of medicine closet; - Client #1 went inside the medicine closet; - Client #1 came out of the medicine closet and went to her room; Interview on 10/17/22 with client #1 revealed: - Unaware if staff was supervising when she was able to go into the medicine closet; - Did not know how many staff worked that evening; - Dis not know how many melatonin pills were taken; - Unable to recall the incident on 10/1/22. Interview on 10/21/22 with staff #1 revealed: - Unaware of the incident with client #1 due to being a part of restraint with client #3; - Staff #2, staff #3 and the Registered nurse #14 assisted with the restraint with client #3; - Unable to provide any further details of client #1 going into medication closet and taking the melatonin pills. Interview on 10/21/22 with staff #2 revealed: -Worked the evening client #1 stole the melatonin out of the medicine closet; -Assisted staff #1, staff #3 and Registered Nurse #14 with a restraint of client #3 when client #1 stole the medication; -Learned about the incident with client #1 when client #1 was in the hospital. Interview on 10/31/22 with the Registered Nurse #14 revealed: - Staff #4 was responsible for supervision of client #1 during the crisis of client #3; - Staff #4 was in the common area providing supervision to clients, while staff #1, #2 and #3	V 314		

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V 314	Continued From page 13 were assisting with crisis of client #3. Interview on 11/1/22 with staff #4 revealed: - Assisted staff with crisis of client #3 on 10/1/22; - Unable to remember the staff that worked with her on 10/1/22; - During the crisis of client #3, the other clients were in their rooms; - Unaware client #1 went inside of the medicine closet and stole melatonin pills on 10/1/22 during the crisis of client #3; - Received a phone call days later from the Program Supervisor about the incident with client #1; - Denied being on the phone during the time of crisis of client #3 and supervision of other clients in the cottage on 10/1/22; - Admitted to being on the phone later during the evening of 10/1/22, but not during crisis of client #3 when client #1 was able to get into medicine closet. Interview on 11/1/22 with the QIS revealed: -Staff #4 entered the common area and sat down in the chair during the crisis of Client #3; - The camera surveillance only showed the bottom half of staff #4 once she sat in the chair; - Staff #4 did not assist the whole time with the crisis of client #3 due to being in the common area with the other clients; - Client #1 was able to come in the common area and go inside the medicine closet with staff #4 sitting in common area in the chair; - Staff #4 did not participate in the meeting and training that followed up from the incident; - The program supervisor met with staff #4 on 10/6/22 to discuss the incident of client #1 being able to steal melatonin out of the medicine closet, but did not provide any trainings	V 314		

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V 314	Continued From page 14 Interview on 11/2/22 with the Chief Performance Quality Officer revealed: -Staff #4 would receive training today (11/2/22) on policies governing supervision and cell phone use. Review on 11/2/22 of the Plan of Protection dated 11/2/22 written by the Quality improvement Specialist revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Program supervisor will hold a training and supervision of RCS (Residential Care Support) staff today 11/2/22 to review policies, job description and scope regulation. Policy reviewed will include: 1. Cell phone policy 2. Residential client supervision policy Describe your plans to make sure the above happens. Staff will sign off on the review of policies and signed policies will be submitted to the program director by the end of business tomorrow (11/3)." The facility served clients with diagnoses of Post Traumatic Stress Disorder, Oppositional Defiant Disorder, Disruptive Mood Dysregulation Disorder, Bipolar Disorder, Current Episode Manic without Psychotic Features, Personal history of self-harm. Client #1 went inside of the medicine closet and stole melatonin pills. Staff #4 sat in a chair straight in line of sight of the medicine closet while client #1 was able to go inside of the closet and steal the medication. Client #1 was able to then come out of the medicine closet and go to her room with the medication. Client #1 took the medicine on the	V 314		

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V 314	Continued From page 15 following day and had to be taken to the hospital. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected with 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 314		
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	V 536		

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V 536	Continued From page 16 by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and	V 536		

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V 536	Continued From page 17 (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.	V 536		

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V 536	Continued From page 18 (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on the record reviews and interviews, the facility failed to ensure 2 of 3 audited staff (staff #4, Registered Nurse (RN) #11)completed annual and refresher training in alternatives to restrictive interventions prior to providing services and 1 of 3 former staff (FS) #9. The findings are: Review on 11/1/22 of Staff #4's personnel record revealed:	V 536		

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V 536	Continued From page 19 - Date of hire 7/11/22; - No training in alternatives to restrictive interventions until 8/12/22. Review on 9/23/22 of Former Staff (FS) #9's personnel record revealed: - Date of hire 10/18/21; - No training in alternatives to restrictive interventions until 4/19/22. -Termination date 7/8/22. Review on 9/23/22 of the Registered Nurse #11's personnel record revealed: - Date of Hire 1/4/2016; -Training in alternatives to restrictive interventions expired 1/4/21. - No documentation of refresher training in alternatives to restrictive interventions. Interview on 10/7/22 with the Quality Improvement Specialist revealed: -"Staff is not in ratio, they can shadow but not officially have hands on until they complete TCI (Therapeutic Crisis Intervention)." Interview on 11/2/22 with the Chief Performance Quality Officer revealed: - Untrained staff are not considered to be part of staff/client ratio.	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	V 537		

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competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.
(b) Prior to providing direct care to people with 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

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rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
(4) strategies for the safe implementation of restrictive interventions;
(5) the use of emergency safety 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

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competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(5) The content of the instructor training the 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);

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V 537	Continued From page 23 (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation 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 2 of 3 audited staff (staff #4, Registered Nurse (RN) #11) annual and refresher training in seclusion, physical restraint and isolation time-out and 1 of 3 Former Staff (FS #9). The finding are: Review on 11/1/22 of Staff #4's personnel record revealed: - Date of hire 7/11/22; - No training in seclusion, physical restraint and isolation time-out until 8/12/22. Review on 9/23/22 of Former Staff (FS) #9's personnel record revealed: - Date of hire 10/18/21; - No training in seclusion, physical restraint and isolation time-out until 4/19/22; -Termination date 7/8/22.	V 537		

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V 537	Continued From page 24 Review on 9/23/22 of the Registered Nurse #11's personnel record revealed: - Date of Hire 1/4/2016; -Training in seclusion, physical restraint and isolation time-out expired 1/4/21. Interview on 10/7/22 with the Quality Improvement Specialist revealed: -"Staff is not in ratio, they can shadow but not officially have hands on until they complete TCI (Therapeutic Crisis Intervention)." Interview on 11/2/22 with the Chief Performance Quality Officer revealed: - Untrained staff are not considered to be part of staff/client ratio.	V 537		
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 observations and interviews the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observations on 9/22/22 at approximately 4:37pm of the facility revealed: -Common area: - Cracks in the flooring and 4 spots peeled	V 736		

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back showing sub flooring ranging in size of 1inch to 5 inches long;
- Approximately 6 different sized spots on the walls had peeled paint and white spray paint over it, the sizes range approximately from 6 inches long to 2 feet long;
- Outside the kitchen door paint peeling on both sides;
- Kitchen door dirty with scuff marks and approximately 10 different sized spots of peeled paint ranging from the size of a dime to 6 inches long and 4 inches wide;
- Beside the exit door were 3 different sized spots of peeled paint and white spray paint sprayed over it.
-Bedroom #3's door old paint in corner of door, writing on the door.

-Hallway to the right
- The end of the hallway on left side peeled paint approximately 9 inches long and 4 inches wide;
- Outside of the therapist's office 2 different sized peeled paint spots ranging in size approximately 3 inches long to 5 inches wide;
- Outside of bedroom #4 approximately 5 different spots of peeled paint on the wall ranging in size approximately 1 inch to 2 feet long.

-Hallway to the left
- Approximately 10 different sized spots of peeled paint with white spray paint sprayed on it, varying in size from 2 inches to 2 ½ feet long;
- Outside of room #2 peeled paint spot approximately 12 inches long and 6 inches wide;
- Outside of bedroom #1 peeled paint approximately 1 ½ feet long 3 ½ inches wide;
- Outside of bedroom #9 approximately 7 different sized spots of peeled paint on the wall ranging in size of approximately a dime to 5

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inches long and 3 inches wide;
- Right side of the hallway approximately 12 different sized spots of peeled paint on the wall ranging in size of approximately of a dime to 1 ½ feet and 5 inches wide.

Review on 9/23/22 of Email correspondence dated 9/23/222 from the Quality Improvement Specialist to the Division of Health Services Regulation (DHSR) Surveyor revealed: "I spoke with our Chief Facilities Officer regarding the issues we discussed yesterday, he stated that he completed a walk through and noted various areas and is working with his team and our contractors to rectify those issues and anticipates correction to be completed in two-three weeks."

Interview on 9/22/22 with the QIS revealed:
- Clients continuously peel the paint off the walls;
- Planned to check with maintenance about painting the cottage.

Interview on 11/2/22 with the Residential Program Director revealed:
- Walk through completed weekly if concerns then staff will complete a Help ticket;
- Once facilities received Help ticket, they come out that day;
- When paint is needed, another ticket is opened and the Residential Program Director is notified about the status of the ticket.