STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL049-074	A. BUILDING: _____ B. WING _____	R 11/21/2022

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 11/21/22. The complaint was substantiated (intake #NC00193126). 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 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.	V 120		

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V 120	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were in a securely locked cabinet affecting 3 of 3 current clients (#1, #2, and #3). The findings are: Review on 11/15/22 of client #1's record revealed: -Admission date of 3/4/03; -Diagnoses of Severe Intellectual Developmental Disability (IDD), Major Depression, Seizure Disorder, Hydrocephalus, and Hypothyroidism; -Physician's orders dated 8/8/12 included Buspirone 10 milligrams (mg), 2 tablets by mouth (po) three times a day (TID) for anxiety, 7/28/14 included Levothyroxine 112 micrograms (mcg), 1 tablet every morning for hypothyroidism, 1/7/15 included Divalproex 125 mg 6 capsules two times a day (BID) for seizures, Loratadine 10 mg, 1 tablet po daily for allergies, Mirtazapine 30 mg, 1 tablet po before bed for depression, and Naltrexone 50 mg, 1 tablet po every morning for self injurious behavior, 7/27/15 included Benztropine .5 mg 1 tablet po BID for drooling, 3/8/19 included Meloxicam 15mg, 1 tablet po daily for back pain, 1/3/20 included Enalapril 5 mg, 1 tablet every morning for blood pressure and Hydrochlorothiazie 12.5 mg, 1 tablet every morning for blood pressure, 5/12/22 included Omeprazole 40 mg, 1 capsule po daily for prophylaxis, 8/15/22 included Fluticasone 50 mcg spray, 1 spray in each nostril daily for allergies, and 10/4/22 included Ferrous Sulfate 325 mg, 1 tablet daily for iron deficiency. Review on 11/15/22 of client #2's record revealed: -Admission date of 1/15/07; -Diagnoses of Moderate IDD, Impulse Control Disorder, Attention Deficit Disorder, Seizure	V 120		

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V 120	Continued From page 2 Disorder, Traumatic Brain Injury (TBI), Anemia, and Chronic Constipation; -Physician's orders dated 10/8/13 included Benztropine .5 mg, 1 tablet po daily for extra-pyramidal symptoms, 1/7/15 included Divalproex 500 mg, 3 tablets po BID for seizures, Loratadine 10 mg, 1 tablet po daily for allergies, Sertraline 100 mg, 1 1/2 tablets po every morning for TBI, and Tizanidine 4 mg, 1/2 tablet TID for muscle relaxant, 10/24/16 included Lamotrigine 100 mg, 1 tablet daily po for impulse control, 11/14/17 included Guanfacine 4 mg Extended Release (ER), 1 tablet po daily for impulse control, and 2/26/18 included Cabergoline .5 mg, 1/2 tablet po twice a week on Monday and Thursday for hormone imbalance. Review on 11/15/22 of client #3's record revealed: -Admission date of 4/4/16; -Diagnoses of Moderate IDD, Autism, Sleep Apnea, Allergic Rhinitis, Hypertension, Type 2 Diabetes Mellitus, Bipolar Disorder, Intermittent Explosive Disorder, and Barretts Esophagus; -Physician's orders dated 4/3/16 included Atorvastatin 10 mg, 1 tablet po before bed for Hypertension and Fluvoxamine 100 mg, 1 tablet po TID for autism, 11/2/16 included Motelukast 10 mg, 1 tablet po daily for bronchospasm, 2/22/17 included Aspirin Low Enteric Coated (EC) 81 mg, 1 tablet po daily for circulation, 3/8/17 included Metformin 500 mg, 1 tablet po BID for diabetes, 10/12/18 included Amlodipine 10 mg, 1 tablet po every morning for blood pressure, and 8/9/22 included Benazepril 20 mg, 1 tablet po BID for Hypertension and Fluticasone Spray 50 mcg, 1 spray in each nostril daily for allergies. Reviews on 11/15/22 of clients #1, #2, and #3's MARs for the months of August 2022 - October 2022 revealed the physician orders for	V 120		

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V 120	Continued From page 3 medications were included. Interview on 11/21/22 with staff #3 revealed: -Title of Direct Support Associate; -Clients were moved out of the facility for approximately a month while the facility was being renovated; -Client medications were not kept securely locked while they were out of the facility; -Was aware that medications were required to be kept locked. Interview on 11/15/22 with staff #2 revealed: -Title of Mentor; -Clients were moved out of the facility for approximately a month to a month and a half (August 2022 - September 2022) while the facility was being renovated; -Staff #1 had provided 3 storage boxes that were utilized to store client medications; -It was not possible to lock the storage boxes and a lock was not provided; -Was aware that medications were required to be kept securely locked. Interview on 11/21/22 with staff #1 revealed: -Title of Residential Team Lead; -Clients were moved out of the facility for 3-4 weeks while the facility was being remodeled; -"I had to get totes (storage boxes) and stuff (lock and dividers) for their (clients) medications...I had to go out and purchase bins (storage boxes);" -Clients were first moved to a rental home and there was no cabinet available to secure the medications; -Clients were then moved to a hotel and there was a cabinet to secure medications; -Was not aware that medications were not kept secured while clients were staying in a hotel; -"The closet was right there where they (staff)	V 120		

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V 120	Continued From page 4 could have seen it." Interview on 11/15/22 with the facility Nurse revealed: - "That (leaving medications unsecured) is not our protocol;" -"They're trained that at medication training. You don't leave the medication closet unlocked;" -Staff #1 had been provided with metal combination locks in order to secure client medications.	V 120		
V 139	27G .0404 (F-L) Operations During Licensed Period 10A NCAC 27G .0404 OPERATIONS DURING LICENSED PERIOD (f) DHSR shall conduct inspections of facilities without advance notice. (g) Licenses for facilities that have not served any clients during the previous 12 months shall not be renewed. (h) DHSR shall conduct inspections of all 24-hour facilities an average of once every 12 months, to occur no later than 15 months as of July 1, 2007. (i) Written requests shall be submitted to DHSR a minimum of 30 days prior to any of the following changes: (1) Construction of a new facility or any renovation of an existing facility; (2) Increase or decrease in capacity by program service type; (3) Change in program service; or (4) Change in location of facility. (j) Written notification must be submitted to DHSR a minimum of 30 days prior to any of the following changes: (1) Change in ownership including any	V 139		

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V 139	Continued From page 5 change in partnership; or (2) Change in name of facility. (k) When a licensee plans to close a facility or discontinue a service, written notice at least 30 days in advance shall be provided to DHSR, to all affected clients, and when applicable, to the legally responsible persons of all affected clients. This notice shall address continuity of services to clients in the facility. (l) Licenses shall expire unless renewed by DHSR for an additional period. Prior to the expiration of a license, the licensee shall submit to DHSR the following information: (1) Annual Fee; (2) Description of any changes in the facility since the last written notification was submitted; (3) Local current fire inspection report; (4) Annual sanitation inspection report, with the exception of a day/night or periodic service that does not handle food for which a sanitation inspection report is not required; and (5) The names of individuals who are owner, partners or shareholders holding an ownership or controlling interest of 5% or more of the applicant entity. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide at least 30 days advance notice to the Division of Health Service Regulation (DHSR) of plans to change the location of the facility. The findings are: Review on 10/28/22 of the DHSR Enterprise electronic licensure system revealed there were	V 139		

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V 139	Continued From page 6 no applications for change of facility location. Review on 11/15/22 of client #1's record revealed: -Admission date of 3/4/03; - Diagnoses of Severe Intellectual Developmental Disability (IDD), Major Depression, Seizure Disorder, Hydrocephalus, and Hypothyroidism; -No documentation of notice that the facility planned to change the location of the facility. Review on 11/15/22 of client #2's record revealed: -Admission date of 1/15/07; -Diagnoses of Moderate IDD, Impulse Control Disorder, Attention Deficit Disorder, Seizure Disorder, Traumatic Brain Injury, Anemia, and Chronic Constipation; -No documentation of notice that the facility planned to change the location of the facility. Review on 11/15/22 of client #3's record revealed: -Admission date of 4/4/16; -Diagnoses of Moderate IDD, Autism, Sleep Apnea, Allergic Rhinitis, Hypertension, Type 2 Diabetes Mellitus, Bipolar Disorder, Intermittent Explosive Disorder, and Barretts Esophagus; -No documentation of notice that the facility planned to change the location of the facility. Interviews on 11/15/22 and 11/21/22 with the Administrator revealed: -"They (clients) were relocated because we were doing a whole house renovation;" -Was not able to recall the dates the clients were out of the facility; -Receipts verifying dates were requested on 11/15/22 and 11/21/22 and were not provided prior to exit; -Was not aware that DHSR had to be notified of plans to temporarily change the location of the facility;	V 139		

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V 139	Continued From page 7 -In the future, it would be the responsibility of the Administrator to notify DHSR of changes.	V 139		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by:	V 291		

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V 291	Continued From page 8 Based on record reviews and interviews, the facility failed to ensure participation of the family or legally responsible person for 3 of 3 audited clients (#1, #2 and #3). The findings are: Review on 11/15/22 of client #1's record revealed: -An admission date of 3/4/03; - Diagnoses of Severe Intellectual Developmental Disability (IDD), Major Depression, Seizure Disorder, Hydrocephalus, and Hypothyroidism; -Legal Guardian was appointed on 8/3/15. Interview on 11/15/22 with client #1's Guardian revealed: -Was not informed that client #1 had been temporarily relocated from the facility until he had been out of the facility for 2 weeks; -The Program Manager had called him (date unknown) to inform him that the facility was being remodeled and the clients were being moved from a rental home to a hotel; -Asked the Program Manager why he was not notified prior to the move but received no answer; -Planned to visit while the client was staying at the hotel but rescheduled his visit to after the client returned to the facility. Review on 11/15/22 of client #2's record revealed: -Admission date of 1/15/07; -Diagnoses of Moderate IDD, Impulse Control Disorder, Attention Deficit Disorder, Seizure Disorder, Traumatic Brain Injury, Anemia, and Chronic Constipation; -Family was involved with the client. Review on 11/15/22 of client #3's record revealed: -Admission date of 4/4/16; -Diagnoses of Moderate IDD, Autism, Sleep Apnea, Allergic Rhinitis, Hypertension, Type 2 Diabetes Mellitus, Bipolar Disorder, Intermittent	V 291		

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V 291	Continued From page 9 Explosive Disorder, and Barretts Esophagus; -Legal Guardian was appointed on 12/18/96. Interview on 11/16/22 with client #3's Guardian revealed: -Had not been informed that the client had been temporarily relocated while facility was being remodeled prior to the move; -Was informed by staff (date unknown) that the clients had been moved to a rental home when she called the client and observed him to be in a different environment. Interview on 11/15/22 with staff #2 revealed: -Staff #1 informed her that clients were going to be relocated to a rental home during renovations a week and a half before the move; -Guardians had informed her they were upset because they weren't informed of the relocation; -Was informed by staff #1 that it was the responsibility of the Qualified Professional (QP) to notify Guardians of changes; -"They (QP) didn't do their part." Interview on 11/15/22 with the Program Manager revealed: -Had been filling in as QP while the clients were temporarily relocated from the facility; -Was aware that client #3's Guardian was upset that she was not notified of the relocation prior to the move; -"Ultimately, it came down to I should have contacted the Guardians;" -"We did let them (Guardians) know where they (clients) were going after the 1st move (rental home to hotel)." Interview on 11/15/22 with the Administrator revealed: -"They (clients) were relocated because we were	V 291		

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V 291	Continued From page 10 doing a whole house renovation;" -Was aware that client #3's Guardian was upset that she was not notified of the relocation prior to the move; -It was the responsibility of the Program Manager to notify Guardians of the temporary relocation of clients because he was filling in as the QP at that time.	V 291		
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	V 536		

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V 536	Continued From page 11 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 (C) instructor's name;	V 536		

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V 536	Continued From page 12 (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. (8) Trainers shall complete a refresher	V 536		

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V 536	Continued From page 13 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 interviews and record reviews, the facility failed to ensure 1 of 6 audited staff (Administrator) demonstrated competency prior to providing services by completing training on alternatives to restrictive interventions and 2 of 6 audited staff (Program Manager and staff #2) completed an annual refresher training on alternatives to restrictive interventions. The findings are:	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL049-074	A. BUILDING: _____ B. WING _____	R 11/21/2022

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V 536	Continued From page 14 Review on 11/15/22 of the Administrator's personnel file revealed: -Hire date of 6/6/22; -No documentation of approved training on alternatives to restrictive interventions. Review on 11/15/22 of the Program Manager's personnel file revealed: -Hire date of 7/1/21; -No documentation of approved training on alternatives to restrictive interventions since 7/16/21. Review on 11/15/22 of staff #2's personnel file revealed: -Hire date of 12/5/11; -No documentation of approved training on alternatives to restrictive interventions since 2/8/21. Interviews on 11/15/22 and 11/21/22 with the Program Manager revealed: -Had not completed an annual refresher training on alternatives to restrictive interventions since 7/16/21; -Was not sure who was responsible for ensuring all trainings were completed. Interviews on 11/15/22 and 11/21/22 with the Administrator revealed: -Had not completed training on alternatives to restrictive interventions; -Was not informed that she needed to complete the training.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN	V 537		

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V 537	Continued From page 15 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with 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	V 537		

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the use of restrictive interventions;
(2) guidelines on when to intervene (understanding imminent danger to self and others);
(3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
(4) strategies for the safe implementation of restrictive interventions;
(5) the use of emergency safety 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

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V 537	Continued From page 17	V 537		

and isolation time-out.
(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(5) The content of the instructor training the 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

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V 537	Continued From page 18 documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation 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 interviews and record reviews, the facility failed to ensure 1 of 6 audited staff (Administrator) completed training in seclusion, physical restraint and isolation time out prior to providing services and 2 of 6 audited staff (Program Manager and staff #2) were retrained and demonstrated competence at least annually. The findings are: Review on 11/15/22 of the Administrator's personnel file revealed: -Hire date of 6/6/22; -No documentation of approved training in seclusion, physical restraint and isolation time out.	V 537		

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V 537	Continued From page 19 Review on 11/15/22 of the Program Manager's personnel file revealed: -Hire date of 7/1/21; -No documentation of approved training in seclusion, physical restraint and isolation time out since 7/16/21. Review on 11/15/22 of staff #2's personnel file revealed: -Hire date of 12/5/11; -No documentation of approved training in seclusion, physical restraint and isolation time out since 2/8/21. Interviews on 11/15/22 and 11/21/22 with the Program Manager revealed: -Had not completed an annual refresher training in seclusion, physical restraint and isolation time out since 7/16/21; -Was not sure who was responsible for ensuring all trainings were completed. Interviews on 11/15/22 and 11/21/22 with the Administrator revealed: -Had not completed training in seclusion, physical restraint and isolation time out; -Was not informed that she needed to complete the training.	V 537		